Technical Specifications & Data Submission Procedures for the State of Utah All Payer Database (APD)

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The Utah All Payer Database: Description and Background

Healthcare reform advocates on both the state and national level are calling for increased transparency in our healthcare system. Yet, the healthcare system, as it currently exists, does not lend itself to transparency or the efficient and thorough analysis of data across disparate datasets and payers. Sudden and dramatic reform of the healthcare system as it presently exists is probably not a realistic immediate goal. Rather, deliberate and well-engineered steps toward reform are probably indicated to move the process forward in a realistic manner. The Utah All Payer Database is a very big step forward in this process.

Numerous states including Utah have been collecting inpatient hospital discharge data for several years now. While data derived from inpatient hospital discharge records remains valuable, an increasing number of states have initiated the process of compiling medical and pharmacy claims data across healthcare insurance providers (payers). The databases and analytic processes involved in evaluating and reporting these data are commonly referred to as All Payer Databases or APDs.

On July 8, 2008, the Utah Health Data Committee unanimously approved a health data plan outlining the creation of an All Payer Database. Funding for the Utah All Payer Database (APD) was provided via House Bill 133, Health Care Reform (2008). The Utah Department of Health (UDOH), Office of Health Care Statistics (OHCS) is currently responsible for building and managing the APD. As previously mentioned, other states have APDs; however, **Utah is poised to become the first in the country to analyze episodes of care** (EOC) derived from statewide health insurance claims. An EOC is defined as a complete course of care from the initial diagnosis through treatment and follow-up. For example, in the context of maternity, the EOC would begin with the first prenatal visit and include all other visits, pharmacy claims, lab tests, special procedures, delivery of the baby and postpartum care of the mother.

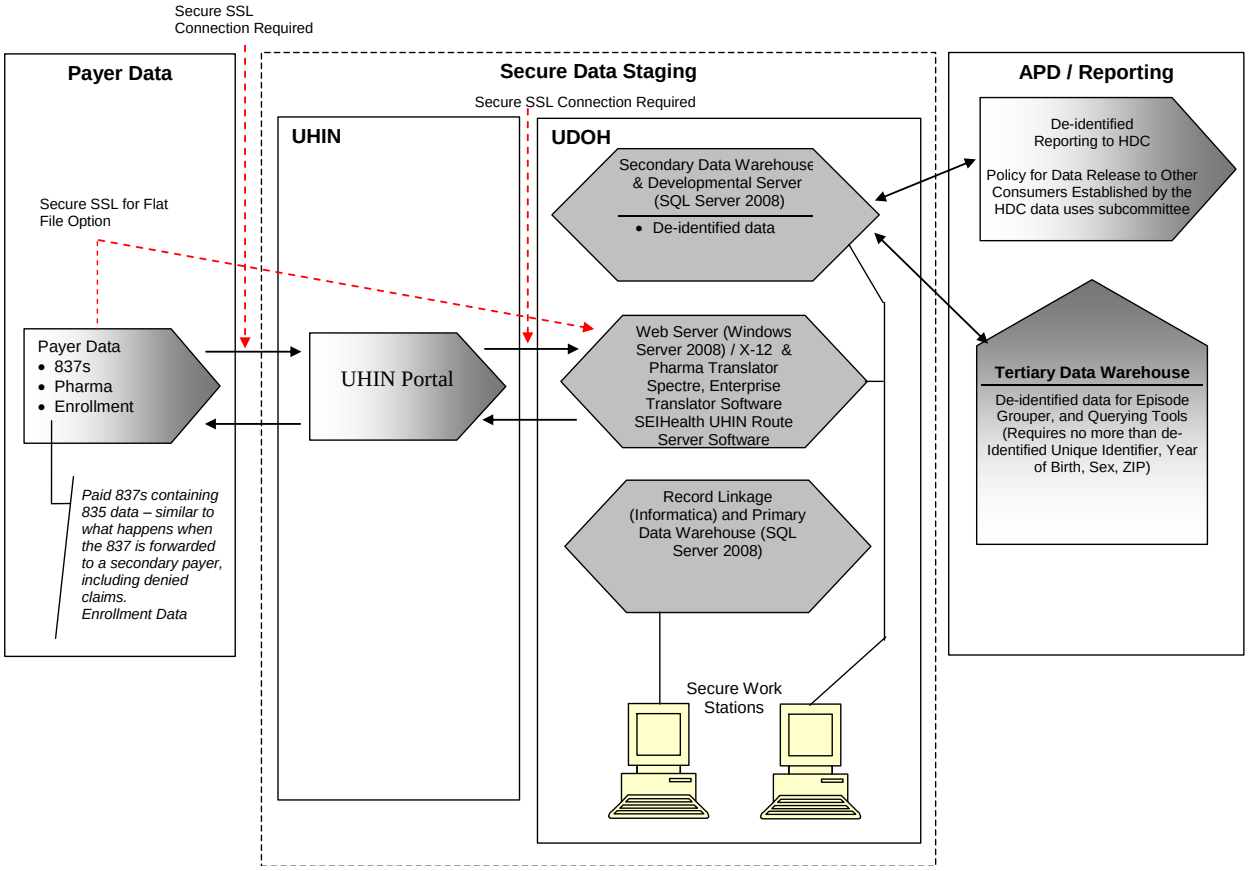
The Utah APD will represent a rich and deep source of health care data capable of answering questions such as:

- What happened?
- When and where did it happen?
- How much did it cost?
- Who paid for what (including healthcare consumer out of pocket costs)?
- What costs were not covered?
- What other influences impact outcome (disease burden, co morbidities, demographics, environmental issues, access to specialists, etc.)?
- What impact does preventive care, or lack there of, have on outcome?
- Verification and examination of standards of care

The APD will assist in the comparison of health care cost efficiencies and effectiveness statewide from both a cross sectional as well as from more longitudinally based disease progression perspective. This will be done through the application of analytic software incorporating sophisticated risk adjustment and disease progression measurement capabilities; so that the costs associated with treating a specific condition in a sicker population will not be compared to treating the same condition in a less medically compromised population. This will reduce or eliminate disparity in cost analysis and allow more accurate comparisons.

The APD will be populated with health care claims data from insurance carriers (including Medicaid) and third party administrators within the state. These data shall consist of modified medical and pharmacy claims as well as healthcare enrollment data. An initial combined payer dataset, estimated at between 100-150 million medical and pharmacy claim records for 2007, 2008, and first quarter, 2009, will be submitted to the OHCS in mid to late 2009. Thereafter, the APD will receive continuous payer claim submissions, estimated at 50-65 million claims annually.

Utah APD Data Flowchart



Purpose

This document describes the technical procedures for submission of the various file formats from data submitters (as defined in R428-15. *Health Data Authority Health Insurance Claims Reporting*)

Forward

The data submitted for the APD are either X12 format or flat text files formatted according to the Specifications set forth by the Office of Healthcare Statistics (OHCS). Data suppliers will transmit data to the state using the Utah Health Information Network (UHIN) for X12 data and either FTP Secure or UHIN Web services for flat text data files. All X12 transactions are 4010 standard.

General

UHIN offers two methods of transport, legacy and Web services. There are also two contexts of a transaction, the Submitter and the Receiver. Transactions can go both directions, always initiated by the route client to the route server. These transactions go through the UHIN Router, so the client calls UHIN, UHIN calls the server, the server replies to UHIN, UHIN tells the client what the server said. In the case of the APD, the State of Utah has a Web Service Route Server to receive files uploaded (pushed) to them. The State also has a Web Services Router Client to request (pull) files from a payer.

For the X12 837 claim submissions, OHCS appears as an additional secondary payer to the submitting payer such as occurs in a payer-to-payer COB transaction. In this case, the primary payer will forward a paid claim to an additional payer including the COB data and other relevant X12 segments.

Data suppliers shall encrypt flat files (as defined in the APD File Requirements) using OpenPGP (either PGP or GPG version 1.4.9). Once encrypted with the APD public key, data suppliers may submit the files using FTPS (FTP Secure/FTP-SSL) to the APD, or through UHIN Web Services.

Data Submissions

Data Supplier Registration

Before submitting to the APD, a data supplier must contact the OHCS and register their submitter ID (UHIN Trading Partner Number or TPN). The OHCS controls who submits to the production system TPN (HT005096-001). The data supplier must also declare the method OHCS should use to receive the data (Web Services or other methods).

Initial Data Submissions

The initial data submission shall be for claims incurred from January 1, 2007 through December 31, 2008 and which are paid through September 30, 2009. Thereafter, data suppliers shall submit monthly health care claims data. Data suppliers must submit using the appropriate file formats and transports. Claim and pharmacy batch sizes will not contain more than one month and are not to exceed the file requirements of the UHIN router, where applicable.

Frequency of Ongoing Data Submissions

Data suppliers will transmit claim data (both services and pharmacy) to the OHCS within 30 days of claims being adjudicated (either paid or denied). Any claims that have been "soft" denied (denied for incompleteness, incorrect or other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim's final adjudication.

UHIN Legacy Route Server (Payer RS)

Most data suppliers who will be transmitting data to the APD already have a dedicated legacy UHIN route server. In order for the APD to fetch files from a router server, data suppliers must set up a download route in the UHIN router. This would include an 837 and an 864 route if sending flat files for Enrollment and/or Pharmacy claims via UHIN. Data suppliers must also set up upload routes for the 997, 277FE and 864 if receiving XML response files via UHIN. The OHCS server will poll for available files once an hour and download (and archive) all available files. The OHCS will push files to a legacy router upon processing the incoming files.

OHCS has two UHIN trading partner numbers for submitting X12 Transactions. TPN HT005096-001 is for production (P) only and TPN HT005096-002 is for submitting test (T) files. OHCS will also use ISA15 Usage Indicator for X12 transactions to determine if submissions are for production (P) or test (T). The Usage Indicator will be ignored by submissions to HT005096-002. OHCS will not accept submissions to HT005096-001 with an ISA15 value of (T).

Data suppliers who wish to have their files pulled from their route servers will have to develop a procedure with the OHCS so that the system knows to push their responses to them rather than place them in the router server outbound queues.

Flat Files and File Names

In order to have seamless compatibility with UHIN web services processing the APD will use the same naming standards for both transport methods. Data suppliers shall send the file name in the TransmissionHeader.message field of each UHIN Web services SOAP request. FTP Secure automatically sends the file name with the

Transmission. The format of the file name is as follows (Note: The Underscores (_) and Dashes(-) are important to the UHIN Router and may not be interchanged):

RECEIVERTPID_DATETIMESTAMP_SUBMITTERTPID-UNIQUEIDENTIFIER.TRANTYPE[1]

Where RECEIVERTPID equals the file receiver. For files inbound to the APD this will be HT005096-001. The DATETIMESTAMP should be in the format YYYYMMDDHHNNSS, where

YYYY=Current Year
MM=Current Month, Zero Padded
DD=Current Day of Month, Zero Padded
HH=Current Hour, 24 hour clock, Zero Padded
NN=Current Minutes of the hour, Zero Padded
SS= Current Seconds of the minute, Zero Padded

The SUBMITTERTPID will equal the UHIN TPN of the entity sending the data; on inbound files to the APD this will be the payers TPN. The UNIQUEIDENTIFIER is defined by the Submitter. The total length of the file name may not exceed 60 characters. The TRANTYPES used at this time will be as follows:

TRANTYPE Code	Description
837	X12 Claim Files
TXT	Text File Type
ASC	Encrypted FlatFile
997	X12 Response File
277	X12 Claim Level Response
RXF	Pharmacy FlatFile
ENR	Enrollment FlatFile
864	X12 Text File
XML	XML Response File

Example Claim File Name:

HT005096-001_20090410123421_HT000015-002-B0001.837

Example Enrollment File Name:

HT005096-001_20090410123421_HT000015-002-EN0001.ENR

Example Enrollment File Name (GPG encrypted ASCII armored):

HT005096-001_20090410123421_HT000015-002-EN0001.ENR.ASC

Notes: Since both flat file types have distinctly different record lengths (terminated by CRLF), the record length will determine how the file will be processed. Also OpenPGP encrypted files will ALWAYS begin with "`-----BEGIN PGP MESSAGE-----`" Files will be inspected for encryption when received and encrypted upon receipt if they are not.

[1] UHINet II Technical Reference Manual (Version Dec 2008) in chapter 17

File Sizes
The UHIN Router has been tested to accept files up to 64 Mb in size. ASCII Armored GPG compression will yield effective sizes to 700 Mb (decrypted / decompressed). Data suppliers using FTP Secure do not have any file size restrictions.

Other Notes
Spectre (a contractor supporting technical consultation and development for the Utah APD) will provide a web services client application for no cost to the payers who wish to use it to submit their files to the state. It is a Windows Dot Net 2.0 application and requires the system requirements as such.

Responses to Submissions
The APD process will deliver batch and line level responses to all data submissions. This means a 997, 277(FE) for X12 Claim files and/or XML Response for flat files would be delivered to data suppliers to let them know if their batches and or individual claims, etc were accepted or not. No TA1 will be provided for Files submitted through UHIN because if UHIN cannot open and evaluate the claim file it will not forward it on to the APD.

Data suppliers will be expected to Archive / Delete response files from the State servers after they have been downloaded. Response files will only remain on the outbound server queue for a number of days (60), then will automatically be archived.

X12 Batch Responses
X12 837 claim files which are received by the OHCS will have a 997 (4010) response file generated for transmission back to the data supplier within 24 hours of receipt of files. The 997 will be a standard response for the 837, see appropriate Implementation Guide for details.

X12 Claim Level Responses
X12 837 will have a 277 (4020x070 FE) claim level response file generated for transmission back to the data supplier within 24 hours of processing and acceptance of claims. This will only occur if the X12 Batch was accepted. See UHIN Standard 20 for details.

Flat File Batch / Record Responses
Pharmacy and Enrollment flat files will receive an XML response to the acceptance or rejection of the batch due to improper formatting issues. The file will also contain a record level response and define any errors which occur. The same XML response format will be used for both file types.

The XML file will be provided with a Schema file and XLS transform (Xquery) to permit viewing/printing using a standard (XML 1.0) web browser. Additional style sheets may be added to transform the XML data into comma-delimited files for use with other data systems.

The current version of the APD Response XML Schema will be posted and maintained on the Spectre Health APD Support website at (http://www.seihealth.com/utah_apd). Updates / Changes to the XML Schema will permit enhancements without breaking legacy systems using prior versions of the APD Response files.

APD **Response** Element contains the following elements:

Element Name	Element Type	Remarks
FileName	xs: string	Name of the file submitted by user. May also be the name UHIN submitted through system
SubmitterId	xs: string	UHIN TPN of Submitter
DateTime	xs: dateTime	Date and Time accepted and processed through APD front end edits.
AcceptanceCode	xs: string	A=Accepted, R=Rejected, E=Accepted with Errors.
APDFileId	xs: int	APD assigned file tracking number.
APDFileType	xs: string	Type of file being responded to, either Enrollment or Pharmacy
DataRecord	xs:complexType	Response for individual Records. See complete definition below.
RecordCount	xs: int	Simple line count of records

The **DataRecord** Element contains following elements:

Element Name	Element Type	Remarks
DataRecordNo	xs: int	Simple line number count of data record
APDRecordId	xs: int	APD Database Record Reference number
AcceptanceCode	xs: string	A=Accepted, R=Rejected
Error	xs:complexType	Class for describing error if present. May be NULL if no error with this record. May be repeated if several errors in a single record. See below for complete definition

The **Error** Element contains following elements:

Element Name	Element Type	Remarks
APDErrorId	xs: int	Error Number for APD Front End Edit
FieldId	xs: int	Field Number from APD File Requirement specs
FieldName	xs: string	Name of the Field from the APD File Requirement Specs
FieldData	xs: string	Erroneous data
Description	xs: string	Description of Error

Sample XML Response File

```
<?xml version="1.0" encoding="UTF-8"?>
<!-- Created by Jeffrey W Holste (Spectre Enterprises Inc) -->
<?xml-stylesheet type="text/xsl" href="ADPresponse.xslt"?>
<Response xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance"
xsi:noNamespaceSchemaLocation="apdresponse.xsd">
      <!--FileName will be echo of Incoming Name-->
      <FileName> HT005096-001_20090410123421_HT000015-002-EN0001.TXT.ASC</FileName>
      <SubmitterId>HT000015-002</SubmitterId>
      <DateTime>2009-04-10T12:35:00</DateTime>
      <AcceptanceCode>A</AcceptanceCode>
      <!-- FileId is from X12 Translator SQL Database Identity Field -->
      <APDFileId>1234567890</APDFileId>
      <APDFileType>Enrollment</APDFileType>
      <DataRecord>
            <DataRecordNo>1</DataRecordNo>
            <APDRecordId>1234567980</APDRecordId>
            <AcceptanceCode>A</AcceptanceCode>
            <Error/>
      </DataRecord>
      <DataRecord>
            <DataRecordNo>2</DataRecordNo>
            <APDRecordId>1234567981</APDRecordId>
            <AcceptanceCode>R</AcceptanceCode>
            <Error>
                  <APDErrorId>1</APDErrorId>
                  <FieldId>16</FieldId>
                  <FieldName>Birthdate</FieldName>
                  <FieldData>20090229</FieldData>
                  <Description>Invalid DateTime</Description>
            </Error>
            <Error>
                  <APDErrorId>2</APDErrorId>
                  <FieldId>16</FieldId>
                  <FieldName>Birthdate</FieldName>
                  <FieldData>20090229</FieldData>
                  <Description>Birthdate Required</Description>
            </Error>
      </DataRecord>
      <DataRecord>
            <DataRecordNo>3</DataRecordNo>
            <APDRecordId>1234567982</APDRecordId>
            <AcceptanceCode>A</AcceptanceCode>
            <Error/>
      </DataRecord>
      <RecordCount>3</RecordCount>
</Response>
```

XML Data Using Default Stylesheet

State of Utah Office of Healthcare Statistics
APD Response File Report

Filename: **HT005096-001_20090410123421_HT000015-002-EN0001.TXT.ASC**
File Type: **Enrollment**
Acceptance Code: **A**

RecordNo	AcceptanceCode	APD Record Id	Errors
1	A	1234567980	APDErrorId | Description | FieldData | FieldId | FieldName
2	R	1234567981	APDErrorId: 1 — Description: Invalid DateTime — FieldData: 20090229 — FieldId: 16 — FieldName: Birthdate APDErrorId: 2 — Description: Birthdate Required — FieldData: 20090229 — FieldId: 16 — FieldName: Birthdate
3	A	1234567982	APDErrorId | Description | FieldData | FieldId | FieldName

Record Count: **3**

XMLStyleSheet: *APDresponse.xslt*

Incoming File Acceptance Standards
Incoming X12 files will be required to meet HIPPA Level 1 - X12 Integrity Syntax Testing. HIPPA Level 1 - As defined by ClarEDI[2] is as follows:

> Integrity Testing, according to the WEDI/SNIP White Paper, involves testing "for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 syntax, and compliance with X12 rules."

It is acknowledged that the OHCS acceptance standards are not currently complete and may be reviewed and updated periodically.

NOTE: Initial Data Submission will be exempt from INDIVIDUAL RECORD Acceptance Standards. Data supplier will NOT be required to correct/resubmit individual records that have errors for records in the Initial Data Submission. Batches must meet HIPPA Level 1 as defined herein.

[2] ClarEDI FAQ - https://www.claredi.com/faq.php?faq_id=5#faq64

The following is a list of APD File Acceptance Criteria. *List of APDErrorIds and criteria will be posted on the support web site.*

Dates (if present) must be valid. Only submit blank data (spaces for flat files) if dates are empty. Do not submit 19000101 or other zero value dates.

Numeric Fields may not contain text characters or formatting characters such as dollar ($) or comma (,). Trailing Zeros are permitted.

Flat files will first be tested for proper record lengths. If flat files are of the appropriate record length, the data translator will attempt to parse the records.

At a minimum, the following patient/member information is required.

First Name, Last Name, Street Address, City, State, Zip Code, Sex, Date of Birth, Relationship Code, Member Id (Note: the matching and grouping algorithms employed by the APD process multiple fields in addition to the aforementioned – e.g. middle name/initial, phone number, other plan identification numbers, SSN if present, etc.). The First Name, Last Name, Street Address, City, State, Zip Code, Sex, Date of Birth, Relationship Code, Member Id fields represent must have data for our claims/data matching processes. **All other fields contained in the submission specifications are to be considered required if available.**

For medical claims the APD requires Provider LName and Provider FName. All other fields contained in the submission specifications are to be considered required if available.

Changes in Acceptance Standards
All changes in acceptance standards will be communicated to each data supplier's point of contact recorded at the OHCS. Data suppliers will have 90 days to comply with updated acceptance standards once adopted by OHCS.

Introduction to GnuPG (OpenPGP)

http://www.gnupg.org/ - Pretty Good Privacy (PGP) is an industry standard encryption program using a public/private key method. OpenPGP is the open source version which is implemented in GnuPG (or GPG). GPG is free and supported across many platforms including MS Windows and Unix (Linux). If you have the commercial PGP edition, you may use it as long as you maintain version compatibility.
As an added layer of protection for the PHI data involved with the APD, the OHCS is using GPG for data submissions. A data supplier will use the OHCS public key to encrypt the data to be sent to the APD and then use the previously methods for transport. The other very nice side benefit of this process is the built in compression offered by GPG (bzip2).

If you use the binary encryption, you actually get 8% better compression that standard ZIP, AND the files are fully encrypted without the password vulnerabilities of ZIP files.

Using the ASCII armored output option; you still can gain a compression of about 90%. Then the files may be encapsulated in an 864 X12 envelope if required.

To Import the APD Public Key

1. Save the following Key Block (from beginning to end, including the dashes) to a file called **APD-PUBLIC.ASC** (*Keyname = apd@utah.gov*)

2. Run the following command: *Note: you may have to use the complete path to the GPG.exe file.* **gpg --import APD-PUBLIC.ASC**

```
-----BEGIN PGP PUBLIC KEY BLOCK-----
Version: GnuPG v1.4.9 (MingW32)

mQGiBEnCX7IRBACSPm562UIuCwY1q11IdI8ZgIGUxRZcJKwXXjSzkT54gRwfpkHN
cM9++YejBVicaLuPjJFIhjm5DAdMByutz9C/uoQ7WKVZ/EQ0jEQO7JAtU5B4tA6x
LQci4wU6NHERj65G6bcFhnQ6U1HBqEpj0Pbxz4pfkLTtXuFwz0357xHT8wCgxHHS
0vxQeEP0hGkvTaEchCDrEcED/iwNg6NRwud2w5e8E5HBSncFjeGx6EBiGW1u5y7b
9cl2/i7eDEBVS3PNf/Fb/gNyPTkHQjd138zT8rRFhoBcsKvVJYoyy2ZudUp1a6Tv
i4DA3PMQpojkD+6jXxOltzSAMPjCymTPR6+3We0RvLXmQt8oJiqjo3GmOWEvUKIj
QUqxA/9VYD3ahGQiUuMqKzxnY8nTxYHOaDIRqOnb3ncNSLj48iZoR9vrVAyuyz7Q
xBrFKRobLsOt4C8p3W5JGGkkGrgcfrrk7i7aax9BoPwn6jt6Kji72F3OGMym4ga2
AlmtBepdlSP2wpyvhFor36Gj4Zce+Eu0PkewNGUxseEBQdfxEbRGQWxsIFBheWVy
IERhdGFiYXNlIChBUEQgRGF0YSBTdWJtaXNzaW9uIEVuY3J5cHRpb24gS2V5KSA8
YXBkQHV0YWguZ292PohgBBMRAgAgBQJJwl+yAhsDBgsJCAcDAgQVAggDBBYCAwEC
HgECF4AACgkQIPnoOMPI/DnUTwCgufZzim/UMA4v8rW5DtiFCMMm0LUAn2396bcg
5RIVRW8vMeZX3rbm7GaxuQINBEnCX7IQCAC5PdAg6kgAgDepwF7yPBZf0lTqKZNm
Twy9cRkM3M7AOhIu3L4uOwYyJkwXCI2eVwI3fU2dwwRa+jMXPRCWchqSmAN5Lm+C
pEcLGsoU4BcsvlzW1Zp4dR2Vzj2lg5Eo//7S/Fwv+tcvqkPpYKqiOrOyNK6wM/i8
d7/IzkD+VzSNqBNEDvevDjTlK3UfLfAT/E/rdTZsSsEfwwuutzKtTke31wy6r9eU
eIQ7abTTYlO/SBur0R+k+DB7diIqNMy6jcuVe/0UG9D6a3kZ5qkh89l+zTQNsQcR
tyYVNtGzWDArGkHZiygIx3Z8vGbcZ6qJU4ecStNBFj4EFL2G3j7HmBdvAAMFB/45
P6AxY0KgvVjlP2PbwDYFVVKTadbw9wMqMP+yMR/xZl4LgA3rvAzWLYr5pxVRCRyM
+JX1mWisKbadAKVcltLsipvkIg4Xs+bpf2atleSZxDpQyRhwbP5HfjNEgpqeMX4Z
jhyaR7/MC1ENvM3790E79qd37spLgDq4Tw7SeGoXYdRuQFZud7gQo63eG/rxZ3gp
zChAt6S3b6WaeGcjBRo2gbVvn5UBbhb4069EOC96NyLgabh4s5OQ5p4CQoVn4fjy
uD4yo45DttaoU7XiOdbPpJJBmueWEPInMyPfneOts+Q9GBQZNoHC5Ublm1/MvNx3
nb0bY2nnt+UQMaafh5HQiEkEGBECAAkFAknCX7ICGwwACgkQIPnoOMPI/DlMbgCg
gsCsSF2vFy8ryohsLDcckuwoHC0An2qZRbgyqWVRbfFSrXhDGwBWrvIu
=BAEl
-----END PGP PUBLIC KEY BLOCK-----
```

Once you have imported the key, you should set the trust level so GPG won't prompt you to verify the key each time you encrypt something (*"There is no assurance this key belongs to the named user..".*)

1. Run the command, **gpg --edit-key apd@utah.gov**
2. You will get a Command> Prompt, type the command **trust.**
3. When asked for your decision, select item **5, trust ultimately.**
4. Type **QUIT** when finished. You are now ready to encrypt a file to send.

Note on Key Trust: If you choose to make your own key, you can sign the APD public key and set the trust level lower to keep GPG from prompting you about the validity of the key each time you try to use it. ***gpg --sign-key apd@utah.gov*** *and it will ask you for your pwd to sign the key and verify it's validity.*

To Encrypt a File

Run the command, **gpg -r apd@utah.gov -a -e *FileName.Txt*** where Filename.txt is the name of your file to send. The contents of the file will look something like this

```
-----BEGIN PGP MESSAGE-----
Version: GnuPG v1.4.9 (MingW32)

hQIOA7mACTu1DYs+EAgAtSAwKirAHVsJvD4js46bR8CG1IWvUFSZ8Vqm2ZTxQAsX
uygm0527fdtHkWbLEsKcHbrG0a8JxoIjHwXRvQ2ibsih5DJo+Kmx0HwcXGth0/qp
qXCbgFJR0VZo7RMw9ya2S2jCfyVbibx/iXVpc/AeKqUenD8Ru6u6ZLwCXzquGG8f
...
JG+X6TiU9UzNTLNR2SIgi29ZGefBP9B8PClZ+k4owIn9KzeU2q9PUPPXvC7Y9DyY
fGu26RuMAr74tvIrxA==
=8uHF
-----END PGP MESSAGE-----
```

The Extension of the encrypted file will be changed to .ASC by the program.

You will not be able to decrypt the message file, so archive or store your outbound files. FYI: GPG offers superior compression over ZIP (uses bzip2 by default). Suggest if you archive your files you go ahead and encrypt/compress them using your own key.

To make your own key, run the gpg --gen-key command. Follow the prompts. Once you are done, export your secret (private) key and copy to a safe back immediately.

gpg -a --export-secret-key user@yours.com > mySecretKey.asc

If you ever lose this you will NEVER be able to decrypt your data.

Enrollment File

It is a fixed-length record format totaling 485 characters. Text fields are left justified and padded with spaces. There should be one record per distinct set of eligibility/insurance data.

NOTES:

Subscriber = Policy Holder
Patient = Member (may be Subscriber)
If Subscriber is Patient, Patient Data Should Be BLANK (space)

Right pad all data with spaces, except numeric data.

Field	Data Element	Start Column	Length	
1	Record Type	1	1	Always contains "1"
2	Transaction Code	2	1	Add new member record or change to an existing member record. A for add, C for Change
3	File Create Date	3	8	YYYYMMDD
4	Member ID	11	20	Insurance ID, sometimes referred to as the subscriber ID
5	SSN	31	9	Digits only, no separators
6	Member's Relationship to Subscriber	40	2	01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 09 Adopted Child 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner G8 Other Relationship
7	Last Name	42	35	
8	First Name	77	25	
9	Middle Name	102	25	
10	Sex	127	1	(M)ale, (F)emale, (U)nknown
11	Street	128	55	
12	City	183	30	
13	State	213	2	Two character abbreviation

14	Zip Code	215	15	Either five digits or ten digits including dash, 12345-6789
15	Primary Phone	230	10	Digits only, no separators
16	Birth date	240	8	YYYYMMDD
17	Race	248	6	1. White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. 2. Black or African American - A person having origins in any of the black racial groups of Africa. 3. Native Hawaiian or Other Pacific Islander - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands. 4. Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. 5. American Indian or Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. 6. Unknown This field can be populated by multiple numbers - without separators. For example, A person identifying him/herself as being Pacific Islander and Asian would be coded as 34 or 43.
18	Ethnicity	254	1	1. Not Hispanic or Latino 2. Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. 3. Unknown
19	Primary/Secondary	255	1	(P)rimary, (S)econdary (T)erciary (Q)uaternary
20	Designated Primary Care Physician	256	55	Name string, no punctuation
21	PCP ID	311	20	NPI assigned to field 36, designated PCP
22	Reserved for future use	331	8	
23	Healthplan Code	339	4	This is the code that the Healthplan identifies for themselves - Line of business, HMO, PPO, POS, etc.
24	Benefit Option Code	343	20	This code is assigned by the plan
25	Option Effective Date	363	8	YYYYMMDD
26	HP Termination Date	371	8	YYYYMMDD
27	Employer Group Code	379	20	This code is assigned by the plan
28	Patient ID	399	15	Only used if the patient has a number different from the Member ID
29	Reserved for future use	414	9	
30	Health Plan Description	423	30	Free Text name of Health Plan
31	Orig. HP Effective Date	453	8	Date when you were first enrolled by the payer, still could require an effective date for each year of renewal, see field 25. YYYYMMDD

32	Member Status	461	1	1=Verified, 2=Provisional
33	Reserved for future use	462	1	
34	Reserved for future use	463	1	
35	Reserved for future use	464	1	
36	Reserved for future use	465	1	
37	Reserved for future use	466	10	
38	Reserved for future use	476	10	
			485	

Medical Claims

All X12 format messages must contain all the necessary segments for processing through UHIN or other system which may evaluate the X12 structure. This includes but is not limited to ISA/IEA segments, GS,GE segments, Segment Qualifier codes, etc as specified in the X12 implementation guides. If a segment or qualifier is required for X12 format, it is required whether directly specified in this document or not. If a segment or qualifier is not required for X12 format (may be blank), but is requested by this document, it is required.

The standards set forth by the OHCS represent content requirements above and beyond standard x12 format. During testing we will meet with each payer to review individual submission formatting.

Submitted files must be in the ASC X12 4010A1 x098 for a Professional Claim or the ASC X12 4010A1 x096 for an Institutional claim. The following are those fields required by the APD with specific data values identified.

	Data Element Name		Data Type/Length		Value		
	837P	837I	837P	837I		837P	837I
1	BHT Beginning of Hierarchical Transaction BHT06	BHT01 Hierarchical Structure Code BHT06	ID 2/2	ID 2/2	"RP"	To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time RP Reporting Use RP when the entire ST-SE envelope contains encounters. Use RP when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.	Transaction Type Code O ID 2/2 Code specifying the type of transaction INDUSTRY: Claim or Encounter Identifier ALIAS: Claim or Encounter Indicator 1808 Use RP when the entire ST-SE envelope contains encounter transmissions. Use RP when the transmission is being sent to an entity (usually not a payer or a normal provider-payer transmission itermediary) for purposes other than adjudication of a claim. Such an entity could be a state health agency which is using the 837 for health data reporting purposes.
2	Functional Group Header GS08	Functional Group Header GS08	A/N (1/12)	A/N (1/12)		Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed	Version / Release / Industry Identifier Code M AN 1/12 Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

3	Functional Group Header GS01	Functional Group Header GS01	AN (2/2)	AN (2/2)		Code identifying a group of application related transaction sets	Code identifying a group of application related transaction sets
4	Submitter Name 1000A NM103	Submitter Name 1000A NM103	AN (2/80)	AN (2/80)	Payer Name	Individual last name or organizational name INDUSTRY: Submitter Last or Organization Name ALIAS: Submitter Name	Individual last name or organizational name INDUSTRY: Submitter Last or Organization Name ALIAS: Submitter Name
5	Submitter Identifier 1000A NM109	Submitter Identifier 1000A NM109	AN (2/80)	AN (2/80)	UHIN Payer Trading Partner Number (HT00000-000)	Code identifying a party or other code INDUSTRY: Submitter Identifier ALIAS: Submitter Primary Identification Number SYNTAX: P0809	Code identifying a party or other code INDUSTRY: Submitter Identifier ALIAS: Submitter Primary Identification Number SYNTAX: P0809
6	Submitter EDI Contact Information 1000A PER01-05	Submitter EDI Contact Information 1000A PER01-05	AN (2/80)	AN (2/80)	Contact Information for the payer	Code identifying the major duty or responsibility of the person or group named	Code identifying the major duty or responsibility of the person or group named
7	Receiver Name 1000B NM103	Receiver Name 1000B NM103	AN (2/80)	AN (2/80)	UTAH OHCS	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Receiver Name	Name Last or Organization Name Individual last name or organizational name INDUSTRY: Receiver Name
8	Receiver Identifier 1000B NM109	Receiver Identifier 1000B NM109	AN (2/80)	AN (2/80)	HT005096-001		
9	Billing Provider Name 2010AA NM103	Billing Provider Name 2010AA NM103	AN (2/80)	AN (2/80)	This would Identify the Provider to whom the claims where paid.	Individual last name or organizational name INDUSTRY: Billing Provider Last or Organizational Name ALIAS: Billing Provider Name	Individual last name or organizational name INDUSTRY: Billing Provider Last or Organizational Name ALIAS: Billing Provider Name
10	Billing Provider ID 2010AA NM109	Billing Provider ID 2010AA NM109	AN (2/80)	AN (2/80)	Where NM108=XX for NPI	Individual last name or organizational name INDUSTRY: Billing Provider Last or Organizational Name ALIAS: Billing Provider Name	Individual last name or organizational name INDUSTRY: Billing Provider Last or Organizational Name ALIAS: Billing Provider Name
11	Billing Provider Secondary Identification 2010AA REF02	Billing Provider Secondary Identification 2010AA REF02	AN (1/30)	AN (1/30)	EIN Where REF01=24	Tax Identifiing information of the Provider that was paid	Tax Identifiing information of the Provider that was paid

12	Individual Relationship Code 2000B SBR02	Individual Relationship Code 2000B SBR02	ID (2/2)	ID (2/2)	Equals 18 if subscriber is the patient RELATIONSHIP CODES RelationShip Code Definition 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 09 Adopted Child 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner G8 Other Relationship	Code indicating the relationship between two individuals or entities ALIAS: Relationship Code SEMANTIC: SBR02 specifies the relationship to the person insured.	Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured SEMANTIC: SBR02 specifies the relationship to the person insured.
13	Insured Group or Policy Number 2000B SBR03	Insured Group or Policy Number 2000B SBR03	AN (1/30)	AN (1/30)	Payer Policy Number for this Subscriber	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Insured Group or Policy Number ALIAS: Group or Policy Number SEMANTIC: SBR03 is policy or group number.	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Insured Group or Policy Number ALIAS: Group Number SEMANTIC: SBR03 is policy or group number.
14	Payer Name 2010BB NM103	Payer Name 2010BC NM103	AN (1/30)	AN (1/30)	Payer Name	Individual last name or organizational name	Individual last name or organizational name
15	Subscriber Lname 2010BA NM103	Subscriber Lname 2010BA NM103	AN (1/35)	AN (1/35)	Subscriber Last Name	Individual last name or organizational name INDUSTRY: Subscriber Last Name	Individual last name or organizational name INDUSTRY: Subscriber Last Name
16	Subscriber Fname 2010BA NM104	Subscriber Fname 2010BA NM104	AN (1/25)	AN (1/25)	Subscriber First Name - If the Subscriber has only one name the name should be sent in NM103	Individual first name INDUSTRY: Subscriber First Name	Individual first name INDUSTRY: Subscriber First Name

17	Subscriber Middle Name 2010BA NM105	Subscriber Middle Name 2010BA NM105	AN (1/25)	AN (1/25)	Subscriber Middle Name or Initial	Individual middle name or initial INDUSTRY: Subscriber Middle Name	Individual middle name or initial INDUSTRY: Subscriber Middle Name ALIAS: Subscriber's Middle Initial
18	Subscriber Primary Identifier 2010BA NM109	Subscriber Primary Identifier 2010BA NM109	AN (2/80)	AN (2/80)	Payer assigned Identifier	Code identifying a party or other code INDUSTRY: Subscriber Primary Identifier SYNTAX: P0809	Code identifying a party or other code INDUSTRY: Subscriber Primary Identifier SYNTAX: P0809
19	Subscriber Address1 2010BA N301	Subscriber Address1 2010BA N301	AN (1/55)	AN (1/55)	Required when sent in on claim	Address information INDUSTRY: Subscriber Address Line ALIAS: Subscriber Address 1	Address information INDUSTRY: Subscriber Address Line
20	Subscriber Address2 2010BA N302	Subscriber Address2 2010BA N302	AN (1/55)	AN (1/55)	Required when sent in on claim	Address information INDUSTRY: Subscriber Address Line ALIAS: Subscriber Address 2	Address information INDUSTRY: Subscriber Address Line
21	Subscriber City Name 2010BA N401	Subscriber City Name 2010BA N401	AN (2/30)	AN (2/30)	Required when sent in on claim	Free-form text for city name INDUSTRY: Subscriber City Name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	Free-form text for city name INDUSTRY: Subscriber City Name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
22	Subscriber State 2010BA N402	Subscriber State 2010BA N402	ID (2/2)	ID (2/2)	Required when sent in on claim	Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Subscriber State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Subscriber State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.
23	Subscriber Zip Code 2010BA N403	Subscriber Zip Code 2010BA N403	ID (3/15)	ID (3/15)	Required when sent in on claim	Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Subscriber Postal Zone or ZIP Code ALIAS: Subscriber Zip Code CODE SOURCE 51: ZIP Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Subscriber Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code
24	Subscriber Date of Birth 2010BA DMG02	Subscriber Date of Birth 2010BA DMG02	AN (1/35)	AN (1/35)	CCYYMMDD	Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Subscriber Birth Date ALIAS: Date of Birth - Patient SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.	Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Subscriber Birth Date ALIAS: Date of Birth - Patient SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.
25	Subscriber Gender 2010BA DMG03	Subscriber Gender 2010BA DMG03	AN (1/1)	AN (1/1)	Male Female Unknown	Code indicating the sex of the individual INDUSTRY: Subscriber Gender Code ALIAS: Gender - Patient	Code indicating the sex of the individual INDUSTRY: Subscriber Gender Code ALIAS: Gender - Patient

26	Subscriber Secondary Identification Qualifier 2010BA REF01	Subscriber Secondary Identification Qualifier 2010BA REF01	ID (2/3)	ID (2/3)	1W - Member Identification Number. If NM108 = M1 do not use this code. 23 - Client Number. This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number. IG - Insurance Policy Number SY - Social Security Number	Code qualifying the Reference Identification	Code qualifying the Reference Identification
27	Subscriber Secondary Identification 2010BA REF02	Subscriber Secondary Identification 2010BA REF02	AN (1/30)	AN (1/30)	Additional Payer assigned Subscriber identifiers	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Subscriber Supplemental Identifier SYNTAX: R0203	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Subscriber Supplemental Identifier SYNTAX: R0203
28	Patients Relationship to Insured 2000C PAT01	Patients Relationship to Insured 2000C PAT01	ID (2/2)	ID (2/2)	RELATIONSHIP CODES Relationship Code Definition 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 09 Adopted Child 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner G8 Other Relationship	Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured	Code indicating the relationship between two individuals or entities ALIAS: Patients Relationship to Insured

29	Patient Lname 2010CA NM103	Patient Lname 2010CA NM103	AN (1/35)	AN (1/35)	Conditional data ;This data will be present if the Subscriber is not the Patient	Individual last name or organizational name INDUSTRY: Patient Last Name	Individual last name or organizational name INDUSTRY: Patient Last Name
30	Patient Fname 2010CA NM104	Patient Fname 2010CA NM104	AN (1/25)	AN (1/25)	Conditional data ;This data will be present if the Subscriber is not the Patient	Individual first name INDUSTRY: Patient First Name	Name First O AN 1/25 Individual first name INDUSTRY: Patient First Name
31	Patient Middle Name 2010CA NM105	Patient Middle Name 2010CA NM105	AN (1/25)	AN (1/25)	Conditional data ;This data will be present if the Subscriber is not the Patient	Individual middle name or initial INDUSTRY: Patient Middle Name ALIAS: Patient Middle Initial	Individual middle name or initial INDUSTRY: Patient Middle Name
32	Patient Primary Identifier 2010CA NM109	Patient Primary Identifier 2010CA NM109	AN (2/80)	AN (2/80)	This data must be sent only if the patient is assigned a unique payer identifier.	Code identifying a party or other code INDUSTRY: Patient Primary Identifier ALIAS: Patient's Primary Identification Number SYNTAX: P0809	Code identifying a party or other code INDUSTRY: Patient Primary Identifier SYNTAX: P0809
33	Patient Address1 2010BA/2010CA N301	Patient Address1 2010BA/2010CA N301	AN (1/55)	AN (1/55)	Required when sent in on claim	Address information INDUSTRY: Patient Address Line ALIAS: Patient Address 1	Address information INDUSTRY: Patient Address Line
34	Patient Address2 2010CA N302	Patient Address2 2010CA N302	AN (1/55)	AN (1/55)	Required when sent in on claim	Address information INDUSTRY: Patient Address Line ALIAS: Patient Address 2	Address information INDUSTRY: Patient Address Line
35	Patient City Name 2010CA N401	Patient City Name 2010CA N401	AN (2/30)	AN (2/30)	Required when sent in on claim	Free-form text for city name INDUSTRY: Patient City Name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	Free-form text for city name INDUSTRY: Patient City Name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
36	Patient State 2010CA N402	Patient State 2010CA N402	ID (2/2)	ID (2/2)	Required when sent in on claim	Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Patient State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	Code (Standard State/Province) as defined by appropriate government agency INDUSTRY: Patient State Code COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.
37	Patient Zip Code 2010CA N403	Patient Zip Code 2010CA N403	ID (3/15)	ID (3/15)	Required when sent in on claim	Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Patient Postal Zone or ZIP Code ALIAS: Patient Zip Code CODE SOURCE 51: ZIP Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States) INDUSTRY: Patient Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code

38	Patient Date of Birth 2010CA DMG02	Patient Date of Birth 2010CA DMG02	AN (1/35)	AN (1/35)	Required when sent in on claim	Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Patient Birth Date ALIAS: Date of Birth SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.	Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Patient Birth Date ALIAS: Patient's Date of Birth SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.
39	Patient Gender 2010CA DMG03	Patient Gender 2010CA DMG03	AN (1/1)	AN (1/1)	Conditional data ;This data will be present if the Subscriber is not the Patient	Code indicating the sex of the individual INDUSTRY: Patient Gender Code ALIAS: Gender - Patient	Code indicating the sex of the individual INDUSTRY: Patient Gender Code
40	Patient Secondary Identification Qualifier 2010CA REF01	Patient Secondary Identification Qualifier 2010CA REF01	ID (2/3)	ID (2/3)	1W - Member Identification Number. If NM108 = M1 do not use this code. 23 - Client Number. This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number. IG - Insurance Policy Number SY - Social Security Number	Code qualifying the Reference Identification	Code qualifying the Reference Identification
41	Patient Secondary Identification 2010CA REF02	Patient Secondary Identification 2010CA REF02	AN (1/30)	AN (1/30)	Conditional data ;This data will be present if the Subscriber is not the Patient	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Patient Secondary Identifier SYNTAX: R0203	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Patient Secondary Identifier SYNTAX: R0203

42		Facility Type Code (Type of Bill, Positions 1-3) 2300 CLM05-1		AN (1/3)	011X Hospital Inpatient (Part A) 012X Hospital Inpatient Part B 013X Hospital Outpatient 014X Hospital Other Part B 018X Hospital Swing Bed 021X SNF Inpatient 022X SNF Inpatient Part B 023X SNF Outpatient 028X SNF Swing Bed 032X Home Health 033X Home Health 034X Home Health (Part B Only) 041X Religious Nonmedical Health Care Institutions 071X Clinical Rural Health 072X Clinic ESRD 073X Federally Qualified Health Centers 074X Clinic OPT 075X Clinic CORF 076X Community Mental Health Centers 081X Nonhospital based hospice 082X Hospital based hospice 083X Hospital Outpatient (ASC) 085X Critical Access Hospital		Code identifying the type of facility where services were performed; the first through third positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format INDUSTRY: Facility Type Code

43	Facility Type Code 2300 CLM05-1		AN (1/2)		11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 50 Federally Qualified Health Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facially	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format INDUSTRY: Facility Type Code	
44	Claim Frequency Type Code (Type of Bill, Position 4) 2300 CLM05-3		ID (1/1)		Required for Professional Claim 1=Original 6=Corrected 7=Replacement Send what is received in claim from Provider	Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type INDUSTRY: Claim Frequency Code ALIAS: Claim Submission Reason Code CODE SOURCE 235: Claim Frequency Type Code	

45		Claim Frequency Type Code (Type of Bill, Position 4) 2300 CLM05-3		ID (1/1)	Required for Institutional Claim 1=Admit Through Discharge Claim 7=Replacement of Prior Claim		Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type INDUSTRY: Claim Frequency Code CODE SOURCE 235: Claim Frequency Type Code
46	Original Reference Number 2300 REF02 When REF01=F8	Original Reference Number 2300 REF02 When REF01=F8	A/N (1/30)	A/N (1/30)	This is the Payer Internal Control Number (Claim Number Assigned to this claim during adjudication)	Code qualifying the Reference Identification	Code qualifying the Reference Identification
47	Admissio Date 2300 DTP03 When DTP01=435	Admission Date/Hour 2300 DTP03 When DTP01=435	AN (1/35)	AN (1/35)	Required for inpatient claims only		Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Discharge Hour
48		Institutional Claim Code 2300 CL101 Admission Type		ID (1/1)	For inpatient claims only		Code indicating the priority of this admission CODE SOURCE 231: Admission Type Code
49		Institutional Claim Code 2300 CL102 Admission Source		ID (1/1)	For inpatient claims only		Code indicating the source of this admission CODE SOURCE 230: Admission Source Code
50		Institutional Claim Code 2300 CL103 Patient Status Code		ID (1/2)	For inpatient claims only		Code indicating the source of this admission CODE SOURCE 230: Patient Status Code
51		Diagnosis Related Group (DRG) 2300 HI01-2 When HI01-1=DR		AN (1/30)	Conditional for Inpatient Hospital under DRG contract.		Code indicating a code from a specific industry code list
52		Statement Date 2300 DTP03 when DTP01=434		AN (1/35)	CCYYMMDD		Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Discharge Date
53	Discharge Date 2300 DTP03 WHEN DTP01=096		AN (1/35)		CCYYMMDD		
54		Discharge Hour 2300 DTP03 When DTP01=096		A/N (1/25)	HHMM		Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Discharge Hour
55	Patient Account Number 2300 CLM01	Patient Account Number 2300 CLM01	AN (1/20)	AN (1/20)	Required when sent in on claim	Claim Submitter's Identifier Identifier used to track a claim from creation by the health care provider through payment INDUSTRY: Patient Account Number ALIAS: Patient Control Number	Claim Submitter's Identifier Identifier used to track a claim from creation by the health care provider through payment INDUSTRY: Patient Account Number ALIAS: Patient Control Number
56	Medical Record Number 2300 REF02 When REF01=EA	Medical Record Number 2300 REF02 When REF01=EA	AN (1/30)	AN (1/30)	Required when sent in on claim	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

						INDUSTRY: Medical Record Number	INDUSTRY: Medical Record Number
57	Total Claim Charge Amount 2300 CLM02	Total Claim Charge Amount 2300 CLM02	R (1/18)	R (1/18)	Billed Amount	Monetary amount INDUSTRY: Total Claim Charge Amount ALIAS: Total Submitted Charges SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim.	Monetary amount INDUSTRY: Total Claim Charge Amount ALIAS: Total Claim Charges SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim.
58	Patient Paid Amount 2300 AMT02 When AMT01=F5	Patient Paid Amount 2300 AMT02 When AMT01=F5	R (1/18)	R (1/18)	Patient Paid Amount	Monetary amount INDUSTRY: Patient Amount Paid	Monetary amount INDUSTRY: Patient Amount Paid
59	Coordination Of Benefits Payer Paid Amount 2320 AMT02 WHEN AMT01 = D	Payer Prior Payment 2320 AMT02 WHEN AMT01=C4	R (1/18)	R (1/18)	Amount Paid by the Payer Submitting the claim - not the the previous payer if this is other than a primary claim.	Monetary amount INDUSTRY: Payer Paid Amount	Monetary amount INDUSTRY: Other Payer Patient Paid Amount Prior Payments -Payers
60	Service Facility Name 2310D NM103	Service Facility Name 2310E NM103	AN (1/35)	AN (1/35)	Name of facility where services were rendered.	Individual last name or organizational name INDUSTRY: Laboratory or Facility Name ALIAS: Laboratory/Facility Name	Individual last name or organizational name INDUSTRY: Laboratory or Facility Name ALIAS: Laboratory/Facility Name
61	Service Facility ID Code 2310D NM109	Service Facility ID Code 2310E NM109	AN (2/80)	AN (2/80)	Where NM108=XX for NPI	Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier ALIAS: Laboratory/Facility Primary Identifier SYNTAX: P0809	Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier ALIAS: Laboratory/Facility Primary Identifier SYNTAX: P0809
62	Claim Adjudication Date 2330B DTP03 WHEN DTP01=573	Claim Adjudication Date 2330B DTP03 WHEN DTP01=573	AN (1/35)	AN (1/35)	Date the Claim was Adjudicated (Paid/Denied)	Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Adjudication or Payment Date	Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: Adjudication or Payment Date
63	Coordination of Benefits Allowed Amount 2320 AMT02 when AMT01 = B6	Coordination of Benefits Total Allowed Amount 2320 AMT02 When AMT01=B6	R(1/18)	R(1/18)		Monetary amount INDUSTRY: Allowed Amount	Monetary amount INDUSTRY: Allowed Amount
64	Claim Adjustment Group Code 2320 CAS01	Claim Adjustment Group Code 2320 CAS01	ID(1/2)	ID(1/2)	CO Contractual Obligations CR Correction and Reversals OA Other Adjustments PI Payor Initiated Reductions PR Patient Responsibility	Claim Adjustment Group Code Code identifying the general category of payment adjustment	Claim Adjustment Group Code Code identifying the general category of payment adjustment

65	Claim Adjustment Reason Code 2320 CAS02	Claim Adjustment Reason Code 2320 CAS02	ID(1/5)	ID(1/5)	CoPay, Deductible, Patient Responsibility will all be reported in the claim level CAS Code if the Payer Paid at this level. See Washington Publishing for most recent codes. Co-Pay Example: CAS|PR|2|6.32~	Claim Adjustment reason Code Code identifying the detailed reason the adjustment was made INDUSTRY: Adjustment Reason Code ALIAS: Adjustment Reason Code - Claim Level	Claim Adjustment reason Code Code identifying the detailed reason the adjustment was made INDUSTRY: Adjustment Reason Code
66	Claim Level Adjustment Amount 2320 CAS03	Claim Level Adjustment Amount 2320 CAS03	R(1/18)	R(1/18)	Amount of Adjustment	Monetary amount INDUSTRY: Adjustment Amount ALIAS: Adjusted Amount - Claim Level SEMANTIC: CAS03 is the amount of adjustment. COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.	Monetary Amount Monetary amount INDUSTRY: Adjustment Amount SEMANTIC: CAS03 is the amount of adjustment. COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.
67	Laboratory or Facility Primary Identifier 2310D NM109	Laboratory or Facility Primary Identifier 2310E NM109	AN (2/80)	AN (2/80)	National Provider Identifier	Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier ALIAS: Laboratory/Facility Primary Identifier SYNTAX: P0809	Code identifying a party or other code INDUSTRY: Laboratory or Facility Primary Identifier ALIAS: Laboratory/Facility Primary Identifier SYNTAX: P0809
68		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI02-2 When HI02-1=ZZ PAT Reason for Visit 1		AN (1/30)	ICD.9.CM		Code indicating a code from a specific industry code list INDUSTRY: Patient's Reason for Visit
69		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI02-2 When HI02-1=ZZ PAT Reason for Visit 2		AN (1/30)	ICD.9.CM		Code indicating a code from a specific industry code list INDUSTRY: Patient's Reason for Visit
70		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI02-2 When HI02-1=ZZ PAT Reason for Visit 3		AN (1/30)	ICD.9.CM		Code indicating a code from a specific industry code list INDUSTRY: Patient's Reason for Visit

71		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI02-2 When HI02-1=BJ Admitting DX		AN (1/30)	ICD.9.CM Required For all Inpatient Claims		Code indicating a code from a specific industry code list INDUSTRY: Admitting Diagnosis
72	Principal Diagnosis 2300 HI01 -2	Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI01-2 When HI01-1=BK Principal DX	AN (1/30)	AN (1/30)	Required for all Inpatient claims	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Principal Diagnosis Code
73		Present on Admission Indicator 2300 K3		AN (1/80)	Follow the x12 guidance for POA information		Data in fixed format agreed upon by sender and receiver
74	Diagnosis 2300 HI02 -2	Other Diagnosis Information 2300 HI01-2 When HI01-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
75	Diagnosis 2300 HI03 -2	Other Diagnosis Information 2300 HI02-2 When HI02-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
76	Diagnosis 2300 HI04 -2	Other Diagnosis Information 2300 HI03-2 When HI03-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
77	Diagnosis 2300 HI05 -2	Other Diagnosis Information 2300 HI04-2 When HI04-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
78	Diagnosis 2300 HI06 -2	Other Diagnosis Information 2300 HI05-2 When HI05-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
79	Diagnosis 2300 HI07 -2	Other Diagnosis Information 2300 HI06-2 When HI06-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
80	Diagnosis 2300 HI08 -2	Other Diagnosis Information 2300 HI07-2 When HI07-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	Code indicating a code from a specific industry code list INDUSTRY: Diagnosis Code	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
81		Other Diagnosis Information 2300 HI08-2 When HI08-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	NOT USED HI09 C022 HEALTH CARE CODE INFORMATION	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
82		Other Diagnosis Information 2300 HI09-2 When HI09-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	NOT USED HI10 C022 HEALTH CARE CODE INFORMATION	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis

83		Other Diagnosis Information 2300 HI10-2 When HI10-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	NOT USED HI11 C022 HEALTH CARE CODE INFORMATION	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
84		Other Diagnosis Information 2300 HI11-2 When HI11-1=BF	AN (1/30)	AN (1/30)	ICD.9.CM	NOT USED HI12 C022 HEALTH CARE CODE INFORMATION	Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
85		Other Diagnosis Information 2300 HI12-2 When HI12-1=BF		AN (1/30)	ICD.9 CM		Code indicating a code from a specific industry code list INDUSTRY: Other Diagnosis
86		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI03-2 When HI03-1=BN E-Code 1		AN (1/30)	ICD.9.CM ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: External Cause of Injury Code (E-code)]
87		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI03-2 When HI03-1=BN E-Code 2		AN (1/30)	ICD.9.CM ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: External Cause of Injury Code (E-code)]
88		Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information 2300 HI03-2 When HI03-1=BN E-Code 3		AN (1/30)	ICD.9.CM ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: External Cause of Injury Code (E-code)]
89		Principal Procedure Code 2300 HI01-2 When HI01-1=BR Principal Procedure		AN (1/30)	ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: Primary Procedure
90		Principal Procedure Date 2300 HI01-4 When HI01-1=BR Principal Procedure Date		AN (1/35)	CCYYMMDD		Date Time Period
91		Other Procedure Code 2300 HI01-2 When HI01-1=BQ		AN (1/30)	ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: Other Procedure
92		Other Procedure Date 2300 HI01-4 When HI01-1=BQ		AN (1/35)	CCYYMMDD		Date Time Period

93		Other Procedure Code 2300 HI02-2 When HI02-1=BQ		AN (1/30)	ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: Other Procedure
94		Other Procedure Date 2300 HI02-4 When HI02-1=BQ		AN (1/35)	CCYYMMDD		Date Time Period
95		Other Procedure Code 2300 HI03-2 When HI03-1=BQ		AN (1/30)	ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: Other Procedure
96		Other Procedure Date 2300 HI03-4 When HI03-1=BQ		AN (1/35)	CCYYMMDD		Date Time Period
97		Other Procedure Code 2300 HI04-2 When HI04-1=BQ		AN (1/30)	ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: Other Procedure
98		Other Procedure Date 2300 HI04-4 When HI04-1=BQ		AN (1/35)	CCYYMMDD		Date Time Period
99		Other Procedure Code 2300 HI05-2 When HI05-1=BQ		AN (1/30)	ICD.9.PCS		Code indicating a code from a specific industry code list INDUSTRY: Other Procedure
100		Other Procedure Date 2300 HI05-4 When HI05-1=BQ		AN (1/35)	CCYYMMDD		Date Time Period
101	Rendering Provider Specialty 2310B PRV03 or 2000A	Attending Physician Specialty Information 2000A or 2310A PRV03	Text (10)	Text (10)	These data are the Taxonomy code	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Provider Taxonomy Code ALIAS: Provider Specialty Code	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Provider Taxonomy Code ALIAS: Provider Specialty Code
102	Rendering Provider LName 2310B NM103	Attending Physician LName 2310A NM103	AN (1/35)	AN (1/35)	Provider Last Name	Individual last name or organizational name INDUSTRY: Rendering Provider Last or Organization Name ALIAS: Rendering Provider Last Name	Individual last name or organizational name INDUSTRY: Attending Physician Last Name
103	Rendering Provider FName 2310B NM104	Attending Physician FName 2310A NM104	AN (1/25)	AN (1/35)	Provider First Name	Individual first name INDUSTRY: Rendering Provider First Name	Individual first name INDUSTRY: Attending Physician First Name
104	Rendering Provider Name Middle 2310B NM105	Attending Physician Name Middle 2310A NM105	AN (1/25)	AN (1/25)	Provider Middle Name or Initial	Individual middle name or initial INDUSTRY: Rendering Provider Middle Name	Individual middle name or initial INDUSTRY: Attending Physician Middle Name
105	Rendering Provider Name Suffix 2310B NM107	Attending Physician Name Suffix 2310A NM107	AN (1/10)	AN (1/10)	Provider Suffix	Suffix to individual name INDUSTRY: Rendering Provider Name Suffix ALIAS: Rendering Provider Generation	Suffix to individual name INDUSTRY: Attending Physician Name Suffix

106	Rendering Provider Primary Identifier 2310B NM109	Attending Physician Primary Identifier 2310A NM109	AN (2/80)	AN (2/80)	NPI	Code identifying a party or other code INDUSTRY: Rendering Provider Identifier ALIAS: Rendering Provider Primary Identifier SYNTAX: P0809	Code identifying a party or other code INDUSTRY: Attending Physician Primary Identifier SYNTAX: P0809
107	Rendering Provider Secondary Identification 2310B REF02	Attending Physician Secondary Identification 2310A REF02	AN (1/30)	AN (1/30)	Other Payer Identifer	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Rendering Provider Secondary Identifier SYNTAX: R0203	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Attending Physician Secondary Identifier SYNTAX: R0203
108	Line Counter 2400 LX01	Line Counter 2400 LX01	NO (1/6)	AN (1/48)	Submitted as reported on original claim	Number assigned for differentiation within a transaction set ALIAS: Line Counter This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.	Number assigned for differentiation within a transaction set ALIAS: Line Counter This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.
109	Date(s) of Service 2400 DTP03 WHEN DTP01=472	Date(s) of Service 2400 DTP03 WHEN DTP01=472	AN (1/35)	AN (1/35)	CCYYMMDD or range: CCYYMMDD-CCYYMMDD	Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier	Code specifying type of date or time, or both date and time INDUSTRY: Date Time Qualifier
110	Procedure Code 2400 SV101-2	Institutional Service Line Product/Service ID 2400 SV202-2	AN (1/48)	AN (1/48)	HCPCS	Identifying number for a product or service INDUSTRY: Procedure Code	Identifying number for a product or service INDUSTRY: Procedure Code ALIAS: HCPCS Procedure Code
111	Procedure Modifier - 1 2400 SV101-3	Institutional Service Line Procedure Modifier - 1 2400 SV202-3	AN (2/2)	AN (2/2)		This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: Procedure Modifier 1	This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 1
112	Procedure Modifier - 2 2400 SV101-4	Institutional Service Line Procedure Modifier - 2 2400 SV202-4	AN (2/2)	AN (2/2)		This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: Procedure Modifier 2	This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 2
113	Procedure Modifier - 3 2400 SV101-5	Institutional Service Line Procedure Modifier - 3 2400 SV202-5	AN (2/2)	AN (2/2)		This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: Procedure Modifier 3	This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 3
114	Procedure Modifier - 4 2400 SV101-6	Institutional Service Line Procedure Modifier - 4 2400 SV202-6	AN (2/2)	AN (2/2)		This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: Procedure Modifier 4	This identifies special circumstances related to the performance of the service, as defined by trading partners ALIAS: HCPCS Modifier 4
115		Institutional Service Line (Revenue Codes) 2400 SV201		AN (1/48)	Required For Institutional Claims		Identifying number for a product or service INDUSTRY: Service Line Revenue Code SYNTAX: R0102 SEMANTIC: SV201 is

							the revenue code.
116	Days or Units 2400 SV104	Service Units 2400 SV205		R (1/15)	Required For Institutional Claims	Numeric value of quantity INDUSTRY: Service Unit Count ALIAS: Units or Minutes SYNTAX: P0304	Numeric value of quantity INDUSTRY: Service Unit Count ALIAS: Service Line Units SYNTAX: P0405
117	Line Item Charge Amount 2400 SV102	Line Item Charge Amount 2400 SV203	R (1/18)	R (1/18)	Required For Institutional Claims	Monetary amount INDUSTRY: Line Item Charge Amount ALIAS: Submitted charge amount SEMANTIC: SV102 is the submitted charge amount.	Monetary amount INDUSTRY: Line Item Charge Amount ALIAS: Service Line Charge Amount SEMANTIC: SV203 is a submitted charge amount.
118	Allowed Amount 2400 AMT02		R (1/18)		When AMT01=AAE	Monetary Amount INDUSTRY: Approved Amount	
119	Drug Identification 2410 LIN03	Drug Identification 2410 LIN03	AN (1/48)	AN (1/48)	NCPDP Code	Code identifying the type/source of the descriptive number used in Product/Service ID (234) COMMENT: LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU. INDUSTRY: Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234) COMMENT: LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU.
120	Prescription Number 2410 REF02 when REF01=XZ	Prescription Number 2410 REF02 when REF01=XZ	AN (1/30)	AN (1/30)		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier INDUSTRY: Prescription Number ALIAS: Prescription Number SYNTAX: R0203	Code qualifying the Reference Identification ALIAS: Code Qualifier
121	Drug Units Qualifier 2410 CTP05-1	Drug Units Qualifier 2410 CTP05-1	R (1/15)	R (1/15)		Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken ALIAS: Code qualifier	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken ALIAS: Code Qualifier
122	Drug Number of Units 2410 CTP04	Drug Number of Units 2410 CTP04	R (1/15)	R (1/15)		Numeric value of quantity INDUSTRY: National Drug Unit Count ALIAS: National Drug Unit Count SYNTAX: P0405	Numeric value of quantity ALIAS: National Drug Unit Count SYNTAX: P0405
123	Drug Cost or Unit Price 2410 CTP03	Drug Cost or Unit Price 2410 CTP03	R (1/15)	R (1/15)		Price per unit of product, service, commodity, etc. INDUSTRY: Drug Unit Price ALIAS: Drug Unit Price SYNTAX: C1103	Price per unit of product, service, commodity, etc. ALIAS: Drug Unit Price SYNTAX: C1103

124	Line Adjustment Group Code 2430 CAS01	Line Adjustment Group Code 2430 CAS01	ID(1/2)	ID(1/2)	CO Contractual Obligations CR Correction and Reversals OA Other Adjustments PI Payor Initiated Reductions PR Patient Responsibility	Claim Adjustment Group Code Code identifying the general category of payment adjustment	Claim Adjustment Group Code Code identifying the general category of payment adjustment
125	Line Adjustment Reason Code 2430 CAS02	Line Level Adjustment Reason Code 2430 CAS02	ID(1/5)	ID(1/5)	CoPay, Deductible, Patient Responsibility will all be reported in the claim level CAS Code if the Payer Paid at this level. See Washington Publishing for most recent codes. Co-Pay Example: CAS|PR|2|6.32~	Claim Adjustment reason Code Code identifying the detailed reason the adjustment was made INDUSTRY: Adjustment Reason Code ALIAS: Adjustment Reason Code - Line Level	Claim Adjustment reason Code Code identifying the detailed reason the adjustment was made INDUSTRY: Adjustment Reason Code
126	Line Level Adjustment Amount 2430 CAS03	Line Level Adjustment Amount 2430 CAS03	R(1/18)	R(1/18)	This is the adjusted amount.	Monetary amount INDUSTRY: Adjustment Amount ALIAS: Adjusted Amount - Line Level SEMANTIC: CAS03 is the amount of adjustment. COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.	Code identifying the general category of payment adjustment/Code identifying the detailed reason the adjustment was made INDUSTRY: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code/Monetary amount INDUSTRY: Adjustment Amount SEMANTIC: CAS03 is the amount of adjustment. COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.

Pharma Field Requirements

It is a fixed-length record format totaling 1,488 characters. Text fields are left justified and padded with spaces. There should be one record per distinct set of eligibility/insurance data.

NOTES:
Subscriber = Policy Holder
Patient = Member (may be Subscriber)
If Subscriber is Patient, Patient Data Should Be BLANK (space)

Right pad all data with spaces, except numeric data.

Field	Field Name	Start Column	Length	Value
1	Payer Name	1	80	
2	Insured Group or Policy Number	81	30	
3	Subscriber Last name	111	35	Subscriber / Policy Holder Information
4	Subscriber First name	146	25	
5	Subscriber Middle Name	171	25	Name or Initial
6	Subscriber Primary Identifier	196	80	
7	Subscriber Address	276	55	
8	Subscriber Address 2	331	55	
9	Subscriber City	386	30	
10	Subscriber State	416	2	
11	Subscriber Zipcode	418	15	
12	Subscriber Phone	433	10	
13	Subscriber Date of Birth	443	8	Member date of birth. Format: CCYYMMDD (D8)
14	Subscriber Gender	451	1	Member gender. Valid Values: 'M' - Male; 'F' - Female
15	Subscriber Secondary Identification Qualifier	452	2	SECONDARY IDENTIFIERS IDCODE Definition 1W Member Identification Number If NM108 = MI, this qualifier cannot be used. 23 Client Number IG Insurance Policy Number SY Social Security Number
16	Subscriber Secondary Identification	454	30	
17	Patients Relationship to Insured	484	2	RELATIONSHIP CODESRelationShip Code Definition01 Spouse04 Grandfather or Grandmother05 Grandson or Granddaughter07 Nephew or Niece09 Adopted Child10 Foster Child15 Ward17 Stepson or Stepdaughter18 Self19 Child20 Employee21 Unknown22 Handicapped Dependent23 Sponsored Dependent24 Dependent of a Minor Dependent29 Significant Other32 Mother33 Father34 Other Adult36 Emancipated Minor39 Organ Donor40 Cadaver Donor41 Injured Plaintiff43 Child Where Insured Has No Financial Responsibility53 Life PartnerG8 Other Relationship
18	Patient Last name	486	35	Patient / Member Information

19	Patient First name	521	25	
20	Patient Middle Name	546	25	
21	Patient Primary Identifier	571	80	
22	Patient Address	651	55	
23	Patient Address 2	706	55	
24	Patient City	761	30	
25	Patient State	791	2	
26	Patient ZipCode	793	15	
27	Patient Phone	808	10	
28	Patient Date of Birth	818	8	Member date of birth. Format: CCYYMMDD (D8)
29	Patient Gender	826	1	Member gender. Valid Values: 'M' - Male; 'F' - Female
30	Patient Secondary Identification Qualifier	827	3	SECONDARY IDENTIFIERS IDCODE Definition 1W Member Identification Number If NM108 = MI, this qualifier cannot be used. 23 Client Number IG Insurance Policy Number SY Social Security Number
31	Patient Secondary Identification	830	30	
32	RxClaimNo	860	30	Unique prescription claim number. This generally is NOT the individual pharmacy prescription number, but rather the pharmacy benefit manager (PBM) transaction number.
33	RxClaimNoCrossRef	890	30	Refers to the RxClaimNo of related transaction. For adjustments, this field refers to the RxClaimNo of the claim that is being adjusted.
34	RxNo	920	10	Unique prescription number assigned by the pharmacy.
35	PBMMebID	930	40	The pharmacy benefit manager's member id.
36	RXClaimTxnType	970	1	The disposition type associated with this claim line. Values: '0' - Original Claim; '1' - Adjustment; '3' - Reversal; '4' - Replacement; '5' - Dummy Claim
37	RxType	971	1	The channel type used to fill the prescription. Values: '0' - Unknown; '1' - Retail; '2' - Mail Order; '9' - Other
38	RxClaimXrefNo	972	30	Rx Claim cross-reference number. If this is other than an original claim (i.e. reversal, adjustment, etc.), this field contains the RxClaimNo to which this adjustment transaction applies.
39	RxAdjType	1002	2	Adjustment type code. Only valued for adjustment lines to an original RxClaimNo. Identifies the type of adjustment being performed. If valued, either RxClaimXrefNo or RxPairedAdjSeqNo must be valued. Valid Values: '00' - Original claim; '01' - Partial positive adjustment ($ or qty); '02' - Partial negative adjustment ($ or qty); '03' - Full reversal (delete)
40	SubscriberSfx	1004	4	A suffix code applied to the the subscriber or certificate number.

41	RxPrescriberID	1008	80	The prescription's Prescriber ID. This could be almost any number and may be dictated by the PBM. For example, this could be a NPI, DEA, UPIN, or a state ID (like MediCare).
42	RxPrescriberNoType	1088	1	The type of RXPrescriberNo supplied on the record. Valid Values: '0' - NPI, '1' - UPIN; '2' - DEA; '3' - TIN; '4' - State license no; '8' - PBM assigned; '9' - Other
43	RxPrescriberName	1089	80	
44	RxPharmacyNo	1169	20	Pharmacy ID of the pharmacy filling the prescription. This should be the pharmacy's unique NABP (National Association of Boards of Pharmacy) number. Alternately, this could be a unique PBM-assigned identifier.
45	MembMcareSTatus	1189	1	Designates the Medicare status of the Rx claim. Format: 9 Valid Values: '0' - Non-Medicare; '1' - Medicare primary; '2' - Medicare eligible; '3' - Unknown
46	RxWrittenDt	1190	8	The date the original prescription was written. Format: CCYYMMDD (D8)
47	RxFilledDt	1198	8	The date the original prescription was filled Format: CCYYMMDD (D8)
48	Reject Code 1	1206	3	Note: This field has 5 occurrences. Code indicating the error encountered. Values - See "Rx Reject Code" worksheet for values
49	Reject Code 2	1209	3	Note: This field has 5 occurrences. Code indicating the error encountered. Values - See "Rx Reject Code" worksheet for values
50	Reject Code 3	1212	3	Note: This field has 5 occurrences. Code indicating the error encountered. Values - See "Rx Reject Code" worksheet for values
51	Reject Code 4	1215	3	Note: This field has 5 occurrences. Code indicating the error encountered. Values - See "Rx Reject Code" worksheet for values
52	Reject Code 5	1218	3	Note: This field has 5 occurrences. Code indicating the error encountered. Values - See "Rx Reject Code" worksheet for values
53	RxPaidDt	1221	8	The date the prescription claim was paid. Format: CCYYMMDD (D8)
54	RxTotalPdAmt	1229	10	The amount paid by the plan for the prescription. Format: 9999999.99
55	PatientPaidAmount	1239	10	
56	RxQualifier	1249	2	Code qualifying the value found in the 'RxID' field. Space - Not Specified 01 - UPC (Universal Product Codes) 02 - HRI Code (Health Related Item) 03 - NDC (National Drug Code)
57	RxID	1251	19	ID of the product dispensed. The value contained in this field is defined by the 'RxQualifer Field'.

58	RxNDC	1270	11	The full National Drug Code (NDC) of the drug used to fill the prescription. Dashes must be removed and the NDC formatted to a standard 11 character code. See the Additional Data feed Documentation for specific standard formats. See Additional Data Feed Documentation: National Drug Code Format: 99999999999
59	RxTradeNm	1281	50	The trade (brand) name and strength of the drug used to fill the prescription.
60	RxGenericNm	1331	50	The generic name and strength of the drug used to fill the prescription.
61	GCNNumber	1381	14	Generic code of the drug as defined in First Data Bank's Blue Book.
62	GPINumber	1395	14	GPI (Generic Product Identifier)
63	UnitsOfMeasure	1409	2	Indicates the dosage form of the drug Note: Not available for compound drugs. 'space' - Not specified ML - Milliliters GM - Grams EA – Each
64	UnitDoseIndicator	1411	1	A one position field indicating if the drug is packaged in unit dose. Space - Not Specified Y - indicates drug is Unit Dose N - indicates drug is not unit dose.
65	DispensingStatus	1412	1	Indicates if the prescription was a partial fill or the completion of a partial fill. Values: blank = not a partial fill P = partial fill C = completion of partial fill This data is submitted by the pharmacy. Note that if a partial fill is submitted by a pharmacy, this field must be submitted with a 'p' or 'c' value.
66	QuantityIntended	1413	10	Metric decimal quantity that would have been dispensed on original filling if inventory were available. This field is submitted by the pharmacy. Note that this field will only be populated if the claim is for a partial fill.
67	RxMtrcFilQty	1423	15	The metric quantity of the drug used to fill the prescription. Format: 99999.99
68	RxDaysSupplyNo	1438	3	The days supply of medication for this (re)fill of the prescription. Format: 999
69	DrugStrength	1441	10	Drug Strength (e.g. 500MG, 0.5% etc.)
70	DosageDescription	1451	2	See Dosage Description codes

71	CompoundIndicator	1453	1	Indicates if the drug dispensed is a compound 0 = unknown 1 = Not a Compound 2 = Compound
72	RxNoRefills	1454	2	The number of refills on the original prescription. Format: 99
73	RxRefillNo	1456	2	Code identifying whether the prescription is an original (00) or by refill number (01-99) 00 - New 01-99 - Refill number This field represents the Fill Number as submitted by the pharmacy.
74	RxDAWCode	1458	1	The Dispense As Written (DAW) code associated with the prescription. Code indicating whether or not the prescriber's instructions regarding generic substitution were followed. 0 - Not DAW 1 - Physician DAW 2 - Patient DAW 3 - Pharmacy DAW 4 - Generic Not Available 5 - Brand dispensed as generic 6 - Other 7 - Brand drug mandated by Law 8 - Generic drug not available in market 9 - Other Submitted by pharmacy. Note that this field is required to be submitted by pharmacies and therefore should always be populated.
75	Therapeutic ClassCode - AHFS	1459	8	Identifies therapeutic category of drug according to the American Hospital Formulary Service classification system.
76	USC Code	1467	5	USC Code (Universal System of Classification)
77	DEA Class of Drug	1472	1	Indicates abuse potential for a controlled drug: 0 - Not a controlled drug 1 - Used for research only 2 - Most potential for abuse 3 - Less potential for abuse than 2 4 - Less potential for abuse than 2 & 3 5 - Least potential for abuse
78	Drug Class	1473	1	Indicates drug availability to the consumer according to Federal specifications. O=Over the counter F=Federal/Legend (Prescription Only) S=State Restricted I=Insulin

79	Drug Category Code	1474	1	Indicates that a drug product belongs to a category that is commonly treated as an exception in Third Party Plans; categorized by therapeutic class. Values: 0-Unspecified A-Anti-Anxiety Agents B-Fertility Agents C-Contraceptives, Oral D-Diagnostics E-Floride Preparations (excluding Vitalnin Combinations) F-Antiobestiy Drugs/Amphetamines G-Antacids H-Hematinics I-Insulins J-Smoking Deterrents K-AIDS related drugs L-Laxatives M-Reusable Needles (all) N-Disposable Needles (all) O-Reusable Syringes w/wo Needles (Non-Insulin) P-Disposable Syringes w/wo Needles (Non-Insulin) Q-Reusable Syringes w/wo Needles (Insulin) R-Disposable Syringes w/wo Needles (Insulin) S-Diabetic Supplies, Miscellaneous T-Contraceptives, Topical U-Products used for approved or unapproved cosmetic indications V-Vitamins, Commonly excluded W-Contraceptives, Implantable Y-Ostomy Supplies Z = Attention Deficit Disorder and Narcolepsy 1 = Impotency Treatment 2 = Growth hormone, GHRH, and related agents
80	RxBrandInd	1475	1	Identifies whether an Rx was filled with the branded drug or with a generic. Valid Values: '0' - Rx filled with a generic; '1' - Rx filled with the brand drug.
81	RecordDateTimeStamp	1476	12	The date on which the record was last updated on record's source system. Format: CCYYMMDDHHMM (DT)
		1488	1487	

Adjustment Reason Codes

Claim Adjustment Reason Code
2320 CAS02

ReasonCode	CodeDescription
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age. Note: Changed as of 6/02
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Changed as of 6/02
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Changed as of 6/02
9	The diagnosis is inconsistent with the patient's age.
10	The diagnosis is inconsistent with the patient's gender. Note: Changed as of 2/00
11	The diagnosis is inconsistent with the procedure.
12	The diagnosis is inconsistent with the provider type.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. Note: Changed as of 2/01
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Note: Changed as of 2/02 and 6/06
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Note: Changed as of 2/02 and 6/06
18	Duplicate claim/service.
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	Claim denied because this injury/illness is covered by the liability carrier.
21	Claim denied because this injury/illness is the liability of the no-fault carrier.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits. Note: Changed as of 2/01
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments Note: Changed as of 2/01, and 6/05
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. Note: Changed as of 6/00
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided. Note: Inactive for 004010, since 6/98. Redundant to codes 26&27.
29	The time limit for filing has expired.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.

33 Claim denied. Insured has no dependent coverage.
34 Claim denied. Insured has no coverage for newborns.
35 Lifetime benefit maximum has been reached. Note: Changed as of 10/02
36 Balance does not exceed co-payment amount. Note: Inactive for 003040
37 Balance does not exceed deductible. Note: Inactive for 003040
38 Services not provided or authorized by designated (network/primary care) providers. Note: Changed as of 6/03
39 Services denied at the time authorization/pre-certification was requested.
40 Charges do not meet qualifications for emergent/urgent care.
41 Discount agreed to in Preferred Provider contract. Note: Inactive for 003040
42 Charges exceed our fee schedule or maximum allowable amount. Note: Changed as of 10/06. This code will be deactivated on 6/1/2007.
43 Gramm-Rudman reduction. Note: Changed as of 6/06. This code will be deactivated on 7/1/2006.
44 Prompt-pay discount.
45 Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). Note: Changed as of 10/06
46 This (these) service(s) is (are) not covered. Note: Inactive for 004010, since 6/00. Use code 96.
47 This (these) diagnosis(es) is (are) not covered, missing, or are invalid. Note: Changed as of 6/00. This code will be deactivated on 2/1/2006.
48 This (these) procedure(s) is (are) not covered. Note: Inactive for 004010, since 6/00. Use code 96.
49 These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
50 These are non-covered services because this is not deemed a `medical necessity' by the payer.
51 These are non-covered services because this is a pre-existing condition
52 The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed. Note: Changed as of 10/98. This code will be deactivated on 2/1/2006.
53 Services by an immediate relative or a member of the same household are not covered.
54 Multiple physicians/assistants are not covered in this case .
55 Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56 Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer.
57 Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. Note: Inactive for 004050. Split into codes 150, 151, 152, 153 and 154.
58 Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Changed as of 2/01
59 Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules. Note: Changed as of 6/00
60 Charges for outpatient services with this proximity to inpatient services are not covered.
61 Charges adjusted as penalty for failure to obtain second surgical opinion. Note: Changed as of 6/00
62 Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01 and 10/06. This code will be deactivated on 4/1/2007.
63 Correction to a prior claim. Note: Inactive for 003040
64 Denial reversed per Medical Review. Note: Inactive for 003040
65 Procedure code was incorrect. This payment reflects the correct code. Note: Inactive for 003040
66 Blood Deductible.
67 Lifetime reserve days. (Handled in QTY, QTY01=LA) Note: Inactive for 003040
68 DRG weight. (Handled in CLP12) Note: Inactive for 003040

69 Day outlier amount.
70 Cost outlier - Adjustment to compensate for additional costs. Note: Changed as of 6/01
71 Primary Payer amount. Note: Deleted as of 6/00. Use code 23.
72 Coinsurance day. (Handled in QTY, QTY01=CD) Note: Inactive for 003040
73 Administrative days. Note: Inactive for 003050
74 Indirect Medical Education Adjustment.
75 Direct Medical Education Adjustment.
76 Disproportionate Share Adjustment.
77 Covered days. (Handled in QTY, QTY01=CA) Note: Inactive for 003040
78 Non-Covered days/Room charge adjustment.
79 Cost Report days. (Handled in MIA15) Note: Inactive for 003050
80 Outlier days. (Handled in QTY, QTY01=OU) Note: Inactive for 003050
81 Discharges. Note: Inactive for 003040
82 PIP days. Note: Inactive for 003040
83 Total visits. Note: Inactive for 003040
84 Capital Adjustment. (Handled in MIA) Note: Inactive for 003050
85 Interest amount.
86 Statutory Adjustment. Note: Inactive for 004010, since 6/98. Duplicative of code 45.
87 Transfer amount.
Adjustment amount represents collection against receivable created in prior overpayment.
88 Note: Inactive for 004050.
89 Professional fees removed from charges.
90 Ingredient cost adjustment.
91 Dispensing fee adjustment.
92 Claim Paid in full. Note: Inactive for 003040
No Claim level Adjustments. Note: Inactive for 004010, since 2/99. In 004010, CAS at the
93 claim level is optional.
94 Processed in Excess of charges.
95 Benefits adjusted. Plan procedures not followed. Note: Changed as of 6/00
Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP
96 Reject Reason Code.) Note: Changed as of 6/06
Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Note: Changed as of 2/99 and
97 10/06.
The hospital must file the Medicare claim for this inpatient non-physician service. Note: Inactive
98 for 003040
99 Medicare Secondary Payer Adjustment Amount. Note: Inactive for 003040
100 Payment made to patient/insured/responsible party.
Predetermination: anticipated payment upon completion of services or claim adjudication.
101 Note: Changed as of 2/99
102 Major Medical Adjustment.
103 Provider promotional discount (e.g., Senior citizen discount). Note: Changed as of 6/01
104 Managed care withholding.
105 Tax withholding.
106 Patient payment option/election not in effect.
Claim/service adjusted because the related or qualifying claim/service was not identified on
107 this claim. Note: Changed as of 6/03 and 10/06.
108 Payment adjusted because rent/purchase guidelines were not met. Note: Changed as of 6/02
Claim not covered by this payer/contractor. You must send the claim to the correct
109 payer/contractor.
110 Billing date predates service date.
111 Not covered unless the provider accepts assignment.
Payment adjusted as not furnished directly to the patient and/or not documented. Note:
112 Changed as of 2/01

113 Payment denied because service/procedure was provided outside the United States or as a result of war. Note: Changed as of 2/01; Inactive for version 004060. Use Codes 157, 158 or 159.
114 Procedure/product not approved by the Food and Drug Administration.
115 Payment adjusted as procedure postponed or canceled. Note: Changed as of 2/01
116 Payment denied. The advance indemnification notice signed by the patient did not comply with requirements. Note: Changed as of 2/01
117 Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care. Note: Changed as of 2/01
118 Charges reduced for ESRD network support.
119 Benefit maximum for this time period or occurrence has been reached. Note: Changed as of 2/04
120 Patient is covered by a managed care plan. Note: Inactive for 004030, since 6/99. Use code 24.
121 Indemnification adjustment.
122 Psychiatric reduction.
123 Payer refund due to overpayment. Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
124 Payer refund amount - not our patient. Note: Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
125 Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Note: Changed as of 2/02 and 6/06
126 Deductible -- Major Medical Note: New as of 2/97
127 Coinsurance -- Major Medical Note: New as of 2/97
128 Newborn's services are covered in the mother's Allowance. Note: New as of 2/97
129 Payment denied - Prior processing information appears incorrect. Note: Changed as of 2/01
130 Claim submission fee. Note: Changed as of 6/01
131 Claim specific negotiated discount. Note: New as of 2/97
132 Prearranged demonstration project adjustment. Note: New as of 2/97
133 The disposition of this claim/service is pending further review. Note: Changed as of 10/99
134 Technical fees removed from charges. Note: New as of 10/98
135 Claim denied. Interim bills cannot be processed. Note: New as of 10/98
136 Claim adjusted based on failure to follow prior payer?s coverage rules. (Use Group Code OA). Note: Changed as of 6/00 and 10/06.
137 Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Note: New as of 2/99
138 Claim/service denied. Appeal procedures not followed or time limits not met. Note: New as of 6/99
139 Contracted funding agreement - Subscriber is employed by the provider of services. Note: New as of 6/99
140 Patient/Insured health identification number and name do not match. Note: New as of 6/99
141 Claim adjustment because the claim spans eligible and ineligible periods of coverage. Note: Changed as of 6/00
142 Claim adjusted by the monthly Medicaid patient liability amount. Note: New as of 6/00
143 Portion of payment deferred. Note: New as of 2/01
144 Incentive adjustment, e.g. preferred product/service. Note: New as of 6/01
145 Premium payment withholding Note: New as of 6/02
146 Payment denied because the diagnosis was invalid for the date(s) of service reported. Note: New as of 6/02
147 Provider contracted/negotiated rate expired or not on file. Note: New as of 6/02
148 Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete. Note: New as of 6/02
149 Lifetime benefit maximum has been reached for this service/benefit category. Note: New as of

10/02
150 Payment adjusted because the payer deems the information submitted does not support this level of service. Note: New as of 10/02
151 Payment adjusted because the payer deems the information submitted does not support this many services. Note: New as of 10/02
152 Payment adjusted because the payer deems the information submitted does not support this length of service. Note: New as of 10/02
153 Payment adjusted because the payer deems the information submitted does not support this dosage. Note: New as of 10/02
154 Payment adjusted because the payer deems the information submitted does not support this day's supply. Note: New as of 10/02
155 This claim is denied because the patient refused the service/procedure. Note: New as of 6/03
156 Flexible spending account payments Note: New as of 9/03
157 Payment denied/reduced because service/procedure was provided as a result of an act of war. Note: New as of 9/03
158 Payment denied/reduced because the service/procedure was provided outside of the United States. Note: New as of 9/03
159 Payment denied/reduced because the service/procedure was provided as a result of terrorism. Note: New as of 9/03
160 Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. Note: New as of 9/03
161 Provider performance bonus Note: New as of 2/04
162 State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. Note: New as of 2/04
163 Claim/Service adjusted because the attachment referenced on the claim was not received. Note: New as of 6/04
164 Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion. Note: New as of 6/04
165 Payment denied /reduced for absence of, or exceeded referral Note: New as of 10/04
166 These services were submitted after this payers responsibility for processing claims under this plan ended. Note: New as of 2/05
167 This (these) diagnosis(es) is (are) not covered. Note: New as of 6/05
168 Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan Note: New as of 6/05
169 Payment adjusted because an alternate benefit has been provided Note: New as of 6/05
170 Payment is denied when performed/billed by this type of provider. Note: New as of 6/05
171 Payment is denied when performed/billed by this type of provider in this type of facility. Note: New as of 6/05
172 Payment is adjusted when performed/billed by a provider of this specialty Note: New as of 6/05
173 Payment adjusted because this service was not prescribed by a physician Note: New as of 6/05
174 Payment denied because this service was not prescribed prior to delivery Note: New as of 6/05
175 Payment denied because the prescription is incomplete Note: New as of 6/05
176 Payment denied because the prescription is not current Note: New as of 6/05
177 Payment denied because the patient has not met the required eligibility requirements Note: New as of 6/05
178 Payment adjusted because the patient has not met the required spend down requirements. Note: New as of 6/05
179 Payment adjusted because the patient has not met the required waiting requirements Note: New as of 6/05
180 Payment adjusted because the patient has not met the required residency requirements Note: New as of 6/05
181 Payment adjusted because this procedure code was invalid on the date of service Note: New as of 6/05
182 Payment adjusted because the procedure modifier was invalid on the date of service Note: New as of 6/05. Modified on 8/8/2005

183	The referring provider is not eligible to refer the service billed. Note: New as of 6/05
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: New as of 6/05
185	The rendering provider is not eligible to perform the service billed. Note: New as of 6/05
186	Payment adjusted since the level of care changed Note: New as of 6/05
187	Health Savings account payments Note: New as of 6/05
188	This product/procedure is only covered when used according to FDA recommendations. Note: New as of 6/05
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service Note: New as of 6/05
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay. Note: New as of 10/05
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers? compensation carrier. Note: New as of 10/05
192	Non standard adjustment code from paper remittance advice. Note: New as of 10/05
193	Original payment decision is being maintained. This claim was processed properly the first time. Note: New as of 2/06
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician Note: New as of 2/06
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service Note: New as of 2/06
196	Claim/service denied based on prior payer's coverage determination. Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, on that date, begin to use value 136.
197	Payment denied/reduced for absence of precertification/authorization Note: New as of 10/06
198	Payment denied/reduced for exceeded, precertification/authorization Note: New as of 10/06
199	Revenue code and Procedure code do not match. Note: New as of 10/06
200	Expenses incurred during lapse in coverage Note: New as of 10/06
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC ?Medicare set aside arrangement? or other agreement. (Use group code PR). Note: New as of 10/06
A0	Patient refund amount.
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Note: Changed as of 10/06
A2	Contractual adjustment. Note: Inactive for version 004060. Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.
A3	Medicare Secondary Payer liability met. Note: Inactive for 004010, since 6/98.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	Non-covered visits.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing.
B12	Claim/service not covered by this payer/processor.
B13	Services not documented in patients' medical records.
B14	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B15	Payment denied because only one visit or consultation per physician per day is covered. Note: Changed as of 2/01
B16	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Changed as of 2/01 and 10/06.
	Payment adjusted because `New Patient' qualifications were not met. Note: Changed as of

	2/01
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current. Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service Note: Changed as of 2/01, 6/05
B19	Claim/service adjusted because of the finding of a Review Organization. Note: Inactive for 003070
B2	Covered visits. Note: Inactive for 003040
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider. Note: Changed as of 2/01
B21	The charges were reduced because the service/care was partially furnished by another physician. Note: Inactive for 003040
B22	This payment is adjusted based on the diagnosis. Note: Changed as of 2/01
B23	Payment denied because this provider has failed an aspect of a proficiency testing program. Note: Changed as of 2/01
B3	Covered charges. Note: Inactive for 003040
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded. Note: Changed as of 2/01
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. Note: Changed as of 2/01. This code will be deactivated on 2/1/2006.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Changed as of 10/98
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a Hospice.
D1	Claim/service denied. Level of subluxation is missing or inadequate. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D10	Claim/service denied. Completed physician financial relationship form not on file. Note: Inactive for 003070, since 8/97. Use code 17.
D11	Claim lacks completed pacemaker registration form. Note: Inactive for 003070, since 8/97. Use code 17.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. Note: Inactive for 003070, since 8/97. Use code 17.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. Note: Inactive for 003070, since 8/97. Use code 17.
D14	Claim lacks indication that plan of treatment is on file. Note: Inactive for 003070, since 8/97. Use code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician. Note: Inactive for 003070, since 8/97. Use code 17.
D16	Claim lacks prior payer payment information. Note: Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [N4].
D17	Claim/Service has invalid non-covered days. Note: Deactivation date changed from 2/1/2207 to 6/30/2007 on 2/8/2007. This code will be deactivated on 6/30/2007. Use code 16 with appropriate claim payment remark code [M32, M33].
D18	Claim/Service has missing diagnosis information. Note: Deactivation date changed from 2/1/2207 to 6/30/2007 on 2/8/2007. This code will be deactivated on 6/30/2007. Use code 16 with appropriate claim payment remark code [MA63, MA65].
D19	Claim/Service lacks Physician/Operative or other supporting documentation Note: Deactivation date changed from 2/1/2207 to 6/30/2007 on 2/8/2007. This code will be deactivated on 6/30/2007. Use code 16 with appropriate claim payment remark code [M29, M30, M35, M66].
D2	Claim lacks the name, strength, or dosage of the drug furnished. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D20	Claim/Service missing service/product information. Note: Deactivation date changed from 2/1/2207 to 6/30/2007 on 2/8/2007. This code will be deactivated on 6/30/2007. Use code 16 with appropriate claim payment remark code [M20, M67, M19, MA67].

D21	This (these) diagnosis(es) is (are) missing or are invalid Note: New as of 6/05. Deactivation date changed from 2/1/2207 to 6/30/2007 on 2/8/2007. This code will be deactivated on 6/30/2007.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D4	Claim/service does not indicate the period of time for which this will be needed. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D5	Claim/service denied. Claim lacks individual lab codes included in the test. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D6	Claim/service denied. Claim did not include patient's medical record for the service. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review.' Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used. Note: Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.
W1	Workers Compensation State Fee Schedule Adjustment Note: New as of 2/00

Dosage Description

Dosage Description

AA - aerosol (ml)
AB - aerosol (gm)
AC - aerosol (ea)
AD - aerosol refill (ml)
AE - aerosol refill (ea)
AF - foam (gm)
AG - aerosol refill (gm)
AH - aerosol w/adapter (ml)
AJ - aerosol w/adapter (gm)
AK - aerosol, powder (ea)
AL - ampul for nebulization (ml)
AM - aerosol, mist
AN - vial, nebulizer
AO - aerosol, breath activated
AP - aerosol, powder (gm)
AQ - aerosol, spray, (gm)
AR - spray, non-aerosol refill (ml)
AS - aerosol, spray (ml)
AT - aerosol, spray w/pump (ml)
AU - spray, non-aerosol (ml)
AV - foam (ml)
AW - aerosol, foam with applicator (gm)
AX - spray, non-aerosol (ea)
AY - aerosol powder, breath activated
AZ - aerosol, powder (ml)
BA - bath (ea)
BB - bath (ml)
BC - bath (gm)
BD - spray, non-aerosol (gm)
CA - capsule (hard, soft, etc.)
CB - capsule, sustained release 12 hr
CC - capsule, sustained release 24 hr
CD - capsule, with inhalation device
CE - capsule, delayed release (enteric coated
CF - capsule, delayed release (obs 06-25-01)
CK - capsule, sprinkle
CM - capsule, multiphasic release
CO - capsule, 12hr sustained release pellets
CP - capsule, 24hr sustained release pellets

CQ - cap seq
CS - capsule, sustained action
CT - capsule, degradable controlled-release
DP - dropperette, single-use drop dispenser
DS - suspension,delayed release,reconst.
EA - each
EB - bar
EC - cake
ED - soap, medicated (ea)
EE - soap, liquid
EF - dental cone
EG - stick (gm)
EH - stick (ea)
EI - cement (gm)
EJ - plaster
EK - poultice
EL - swab, medicated
EM - cone, medicated
EN - tape, medicated
EP - soap, medicated (ml)
ER - soap, medicated (gm)
ET - pads, medicated (ea)
FA - flask for liquids
FB - flask for solids
FI - film, medicated (ea)
FS - sheet (ea)
GA - gas
GH - inhaler (ml)
GI - inhaler (ea)
GJ - inhaler (gm)
GK - disk, with inhalation device
HA - infusion bottle (ea)
HB - infusion bottle (ml)
HC - pipette (ea)
HD - pipette (ml)
HE - allergen
HG - ampul with device (ml)
HH - ampul (ml)
HI - cartridge (ea)
HJ - cartridge (ml)
HK - iv solution, piggyback premix frozen(ml)
HL - bulk bag, injection (gm)
HM - intravenous solution

HN - intravenous solution, piggyback (ea)
HP - intravenous solution, piggyback (ml)
HQ - disposable syringe (ml)
HR - ampul (ea)
HS - vial (sdv,mdv or additive) (ea)
HT - skin test
HU - plastic bag, injection (ea)
HV - vial (sdv,mdv or additive) (ml)
HW - additive syringe (ml)
HX - disposable syringe (ea)
HY - intraperitoneal solution(ml)
HZ - plastic bag, injection (ml)
IA - implant (ea)
JA - jelly (gm)
JB - jel (ml)
JC - gel (ml)
JD - jel (gm)
JE - beads (gm)
JF - gel (ea)
JG - gel (gm)
JH - pudding (ea)
JI - globule
JJ - pudding (gm)
JP - gel in packet (gm)
JS - gel-forming solution
JT - jelly with prefilled applicator (ml)
JU - gel with prefilled applicator (gm)
JV - gel with applicator (gm)
JW - jelly with applicator (gm)
JX - gel with applicator (ml)
JY - solution with applicator (ea)
KA - cream (grams)
KB - cream, sustained release (gm)
KC - suspension, topical (gm)
KD - gel, sustained release (ml)
KL - lubricant
KM - cream (milliliters)
KP - paste
KT - toothpaste
KV - cream with prefilled applicator
KW - cream with applicator
OA - ointment(gm)
OB - ointment(ml)

OC - ointment(ea)
OV - ointment with prefilled applicator
OW - ointment with applicator
PA - powder (gm)
PB - leaves (gm)
PC - crystals
PD - suspension, reconstituted, oral (ml)
PE - powder effervescent (gm)
PF - flakes (gm)
PG - granules;powder-like,non-efervescent(gm)
PH - drops, reconstituted, oral
PI - solution, reconstituted, oral
PJ - suspension, 12 hr sustained release
PK - patch, transdermal weekly
PL - cleanser (gm)
PM - lump (gm)
PN - cleanser (ml)
PO - effpowdpkt
PP - packet
PQ - patch, transdermal biweekly
PR - patch, transdermal 72 hours
PS - adhesive patch, medicated
PU - powder (units)
PV - patch, transdermal 24 hours
PW - tea (ea)
PX - tea (gm)
PY - suspension, 24 hr sustained release
PZ - suspension in packet (ea)
QA - suppository, rectal
QB - insert
QC - suppository, vaginal
QD - suppository, urethral
QF - suspension, reconstituted, oral (gm)
QV - ring, vaginal
RA - solution (gm)
RB - emulsion (gm)
RC - shampoo (gm)
RE - shampoo cream (gm)
RF - syrup (gm)
RG - suspension, microcapsule reconstituted
RL - liquid (gm)
SA - solution, non-oral
SB - fluid extract

SC - suspension, oral (final dose form)
SE - elixir
SF - enema (ml)
SG - enema (ea)
SH - expectorant
SI - liniment
SJ - solution, oral
SK - lotion (ml)
SL - liquid (ml)
SM - mouthwash
SN - suspension, drops(final dosage form)(ml)
SO - drops
SP - spirit
SQ - oil
SR - suspension, topical (ml)
SS - shampoo
ST - syrup
SU - emulsion
SV - granules, effervescent
SW - solution, irrigation
SX - tincture
SY - concentrate, oral
SZ - lotion (gm)
TA - tablet
TB - tablet, soluble
TC - tablet, chewable
TD - disk
TE - tablet dr
TF - tablet, effervescent
TG - gum
TH - tablet, hypodermic
TI - tablet, sustained release 24hr
TJ - tablet, dispersible
TK - gum(gm)
TL - lozenge
TM - tablet, sustained release 12hr
TN - tablet, granule-like or packets
TO - tablet, sustained release 12hr sequentia
TP - pellet
TQ - tablet, sust.release,particles/crystals
TR - tablet, particles/crystals in
TS - tablet, sustained action
TT - troche

TU - tablet, sublingual
TV - tablet, buccal
TW - wafer
TX - pill
TY - tablet, buccal sustained action
TZ - tablet, osmotic laser-drilled form.
UA - tablet seq
UB - tablet, multiphasic release
UD - tablet, dose pack
UE - tablet, sustained action sequential
UL - tablet, dispersible lingual
UN - unit
WA - wax (gm)
WB - tar (gm)
YA - needle, reusable
YB - bulk
YC - syringe, reusable
YD - diaphragm
YE - bandage
YF - lens
YH - needle, disposable
YI - intrauterine device
YJ - syringe, cornwall
YK - kit
YL - syringe, empty disposable
YM - pad
YN - tampon
YO - towelette (ea)
YP - intraperitoneal admin.sets-paraphernalia
YQ - infusion sets-paraphernalia
YR - strip
YT - tape, non-medicated
YU - irrigation set
YV - sponge
YW - swab, non-medicated
YX - intravenous admixture accessories
YY - kit,refill
YZ - blood administration set

Rx Reject Code

Note: This field has 5 occurrences.

Code indicating the error encountered. Note that the values found in this field can vary based on pharmacy vs. member submitted claims (directs).

The following is a list of the values used for rejects submitted by pharmacies.

Values:

ØØØ or ØØ- No Reject Code Applies
Ø1-Missing\invalid bin
Ø2-Missing\invalid version number
Ø3-Missing\invalid transaction code
Ø4-Missing\invalid processor control number
Ø5-Missing\invalid pharmacy number
Ø6-Missing\invalid group number
Ø7-Missing\invalid cardholder id number
Ø8-Missing\invalid person code
Ø9-Missing\invalid birth date
1C-Missing\invalid smoker/non-smoker code
1E-Missing\invalid prescriber location code
1Ø-Missing\invalid patient gender code
11-Missing\invalid patient relationship code
12-Missing\invalid patient location
13-Missing\invalid other coverage cod
14-Missing\invalid eligibility clarification code
15-MISSING\INVALID Date of Service
16-Missing\invalid prescription/service reference number
17-Missing\invalid fill number
19-Missing\invalid days supply
2C-Missing\invalid pregnancy indicator
2E-Missing\invalid primary care provider id qualifier
2Ø-Missing\invalid compound code
21-Missing\invalid product/service id
22-Missing\invalid dispense as written (daw)/product selection code
23-Missing\invalid ingredient cost submitted
25-Missing\invalid prescriber id
26-Missing\invalid unit of measure
28-Missing\invalid date prescription written
29-Missing\invalid number refills authorized
3A-Missing\invalid request type
3B-Missing\invalid request period date-begin
3C-Missing\invalid request period date-end
3D-Missing\invalid basis of request
3E-Missing\invalid authorized representative first name
3F-Missing\invalid authorized representative last name
3G-Missing\invalid authorized representative street address
3H-Missing\invalid authorized representative city address
3J-Missing\invalid authorized representative state/province address
3K-Missing\invalid authorized representative zip/postal zone
3M-Missing\invalid prescriber phone number

3N-Missing\invalid prior authorized number assigned
3P-Missing\invalid authorization number
3R-Prior authorization not required
3S-Missing\invalid prior authorization supporting documentation
3T-Active prior authorization exists resubmit at expiration of prior authorization
3W-Prior authorization in process
3X-Authorization number not found
3Y-Prior authorization denied
32-Missing\invalid level of service
33-Missing\invalid prescription origin code
34-Missing\invalid submission clarification code
35-Missing\invalid primary care provider id
38-Missing\invalid basis of cost
39-Missing\invalid diagnosis code
4C-Missing\invalid coordination of benefits/other payments count
4E-Missing\invalid primary care provider last name
4Ø-Pharmacy not contracted with plan on date of service
41-Submit bill to other processor or primary payer
5C-Missing\invalid other payer coverage type
5E-Missing\invalid other payer reject count
5Ø-Non-matched pharmacy number
51-Non-matched group id
52-Non-matched cardholder id
53-Non-matched person code
54-Non-matched product/service id number
55-Non-matched product package size
56-Non-matched prescriber id
58-Non-matched primary prescriber
6C-Missing\invalid other payer id qualifier
6E-Missing\invalid other payer reject code
6Ø-Product/service not covered for patient age
61-Product/service not covered for patient gender
62-Patient/card holder id name mismatch
63-Institutionalized patient product/service id not covered
64-Claim submitted does not match prior authorization
65-Patient is not covered
66-Patient age exceeds maximum age
67-Filled before coverage effective
68-Filled after coverage expired
69-Filled after coverage terminated
7C-Missing\invalid other payer id
7E-Missing\invalid dur/pps code counter
7Ø-Product/service not covered
71-Prescriber is not covered
72-Primary prescriber is not covered
73-Refills are not covered
74-Other carrier payment meets or exceeds payable
75-Prior authorization required
76-Plan limitations exceeded
77-Discontinued product/service id number
78-Cost exceeds maximum
79-Refill too soon
8C-Missing\invalid facility id

8E-Missing\invalid dur/pps level of effort
8Ø-Drug-diagnosis mismatch
81-Claim too old
82-Claim is post-dated
83-Duplicate paid/captured claim
84-Claim has not been paid/captured
85-Claim not processed
86-Submit manual reversal
87-Reversal not processed
88-Dur reject error
89-Rejected claim fees paid
9Ø-Host hung up
91-Host response error
92-System unavailable/host unavailable
*95-Time out
*96-Scheduled downtime
*97-Payer unavailable
*98-Connection to payer is down
99-Host processing error
AA-Patient spenddown not met
AB-Date written is after date filled
AC-Product not covered non-participating manufacturer
AD-Billing provider not eligible to bill this claim type
AE-Qmb (qualified medicare beneficiary)-bill medicare
AF-Patient enrolled under managed care
AG-Days supply limitation for product/service
AH-Unit dose packaging only payable for nursing home recipients
AJ-Generic drug required
AK-Missing\invalid software vendor/certification id
AM-Missing\invalid segment identification
A9-Missing\invalid transaction count
BE-Missing\invalid professional service fee submitted
B2-Missing\invalid service provider id qualifier
CA-Missing\invalid patient first name
CB-Missing\invalid patient last name
CC-Missing\invalid cardholder first name
CD-Missing\invalid cardholder last name
CE-Missing\invalid home plan
CF-Missing\invalid employer name
CG-Missing\invalid employer street address
CH-Missing\invalid employer city address
CI-Missing\invalid employer state/province address
CJ-Missing\invalid employer zip postal zone
CK-Missing\invalid employer phone number
CL-Missing\invalid employer contact name
CM-Missing\invalid patient street address
CN-Missing\invalid patient city address
CO-Missing\invalid patient state/province address
CP-Missing\invalid patient zip/postal zone
CQ-Missing\invalid patient phone number
CR-Missing\invalid carrier id
CW-Missing\invalid alternate id
CX-Missing\invalid patient id qualifier

CY-Missing\invalid patient id
CZ-Missing\invalid employer id
DC-Missing\invalid dispensing fee submitted
DN-Missing\invalid basis of cost determination
DQ-Missing\invalid usual and customary charge
DR-Missing\invalid prescriber last name
DT-Missing\invalid unit dose indicator
DU-Missing\invalid gross amount due
DV-Missing\invalid other payer amount paid
DX-Missing\invalid patient paid amount submitted
DY-Missing\invalid date of injury
DZ-Missing\invalid claim/reference id
EA-Missing\invalid originally prescribed product/service code
EB-Missing\invalid originally prescribed quantity
EC-Missing\invalid compound ingredient component count
ED-Missing\invalid compound ingredient quantity
EE-Missing\invalid compound ingredient drug cost
EF-Missing\invalid compound dosage form descriptin code
EG-Missing\invalid compound dispensing unit form indicator
EH-Missing\invalid compound route of administration
EJ-Missing\invalid originally prescribed product/service id qualifier
EK-Missing\invalid scheduled prescription id number
EM-Missing\invalid prescription/service reference number qualifier
EN-Missing\invalid associated prescription/service reference number
EP-Missing\invalid associated prescription/service date
ER-Missing\invalid procedure modifier code
ET-Missing\invalid quantity prescribed
EU-Missing\invalid prior authorization type code
EV-Missing\invalid prior authorization number submitted
EW-Missing\invalid intermediary authorization type id
EX-Missing\invalid intermediary authorization id
EY-Missing\invalid provider id qualifier
EZ-Missing\invalid prescriber id qualifier
E1-Missing\invalid product/service id qualifier
E3-Missing\invalid incentive amount submitted
E4-Missing\invalid reason for service code
E5-Missing\invalid professional service code
E6-Missing\invalid result of service code
E7-Missing\invalid quantity dispensed
E8-Missing\invalid other payer date
E9-Missing\invalid provider id
FO-Missing\invalid plan id
GE-Missing\invalid percentage sales tax amount submitted
HA-Missing\invalid flat sales tax amount submitted
HB-Missing\invalid other payer amount paid count
HC-Missing\invalid other payer amount paid qualifier
HD-Missing\invalid dispensing status
HE-Missing\invalid percentage sales tax rate submitted
HF-Missing\invalid quantity intended to be dispensed
HG-Missing\invalid days supply intended to be dispensed
H1-Missing\invalid measurement time
H2-Missing\invalid measurement dimension
H3-Missing\invalid measurement unit

H4-Missing\invalid measurement value
H5-Missing\invalid primary care provider location code
H6-Missing\invalid dur co-agent id
H7-Missing\invalid other amount claimed submitted count
H8-Missing\invalid other amount claimed submitted qualifier
H9-Missing\invalid other amount claimed submitted
JE-Missing\invalid percentage sales tax basis submitted
J9-Missing\invalid dur co-agent id qualifier
KE-Missing\invalid coupon type
M1-Patient not covered in this aid category
M2-Recipient locked in
M3-Host pa/mc error
M4-Prescription/service reference number/time limit exceeded
M5-Requires manual claim
M6-Host eligibility error
M7-Host drug file error
M8-Host provider file error
ME-Missing\invalid coupon number
MZ-Error overflow
NE-Missing\invalid coupon value amount
NN-Transaction rejected at switch or intermediary
PA-Pa exhausted/not renewable
PB-Invalid transaction count for this transaction code
PC-Missing\invalid claim segment
PD-Missing\invalid clinical segment
PE-Missing\invalid cob/other payments segment
PF-Missing\invalid compound segment
PG-Missing\invalid coupon segment
PH-Missing\invalid dur/pps segment
PJ-Missing\invalid insurance segment
PK-Missing\invalid patient segment
PM-Missing\invalid pharmacy provider segment
PN-Missing\invalid prescriber segment
PP-Missing\invalid pricing segment
PR-Missing\invalid prior authorization segment
PS-Missing\invalid transaction header segment
PT-Missing\invalid workers' compensation segment
PV-Non-matched associated prescription/service date
PW-Non-matched employer id
PX-Non-matched other payer id
PY-Non-Matched Unit Form/Route of Administration
PZ-Non-matched unit of measure to product/service id
P1-Associated prescription/service reference number not found
P2-Clinical information counter out of sequence
P3-Compound ingredient component count does not match number of repetitions
P4-Coordination of benefits/other payments count does not match number of repetitions
P5-Coupon expired
P6-Date of service prior to date of birth
P7-Diagnosis code count does not match number of repetitions
P8-Dur/pps code counter out of sequence
P9-Field is non-repeatable

RA-Pa reversal out of order
RB-Multiple partials not allowed
RC-Different drug entity between partial & completion
RD-Mismatched cardholder/group id-partial to completion
RE-Missing\invalid compound product id qualifier
RF-Improper order of 'dispensing status' code on partial fill transaction
RG-MISSING\INVALID Associated Prescription/service Reference Number On Completion Transaction
RH-Missing\invalid associated prescription/service date on completion transaction
RJ-Associated partial fill transaction not on file
RK-Partial fill transaction not supported
RM-Completion transaction not permitted with same 'date of service' as partial transaction
RN-Plan limits exceeded on intended partial fill values
RP-Out of sequence 'p' reversal on partial fill transaction
RS-Missing\invalid associated prescription/service date on partial transaction
RT-Missing\invalid associated prescription/service reference number on partial transaction
RU-Mandatory data elements must occur before optional data elements in a segment
R1-Other amount claimed submitted count does not match number of repetitions
R2-Other payer reject count does not match number of repetitions
R3-Procedure modifier code count does not match number of repetitions
R4-Procedure modifier code invalid for product/service id
R5-Product/service id must be zero when product/service id qualifier equals ø6
R6-Product/service not appropriate for this location
R7-Repeating segment not allowed in same transaction
R8-Syntax error
R9-Value in gross amount due does not follow pricing formulae
SE-Missing\invalid procedure modifier code count
TE-Missing\invalid compound product id
UE-Missing\invalid compound ingredient basis of cost determination
VE-Missing\invalid diagnosis code count
WE-Missing\invalid diagnosis code qualifier
XE-Missing\invalid clinical information counter
ZE-Missing\invalid measurement date

DIRECT CLAIM REJECT CODES. The following is a list of the reject codes that will appear for direct claims. Please note that the list of values used in this field may be updated from time to time, additional values beyond those listed may appear.

ØØØ or ØØ- No Reject Code Applies
02 = You have submitted an incorrect ndc number. Please contact your physician or pharmacist.
06 = Dependent code greater than 3
07 = Your claim was for an rx filled after your plan coverage was terminated.
11 = Member id number cannot be identified
12 = Dependent not eligible for benefit on prescription date
13 = Drug cannot be identified

17 = Insured ineligible on prescription date

20 = Your claim was for an rx that was filled during a period that the member was not covered by the plan.

21 = Your claim did not provide a correct member number. Please contact your customer service center/plan sponsor.

22 = Your claim was for a prescription that was filled during a period when the patient was not covered by the plan. Your plan covered member only.

23 = Your claim was for a prescription that was filled during a period when the patient was not covered by the plan.

24 = Prescriptions purchased through a mail service pharmacy should not be submitted for direct reimbursement.

25 = Our records do not indicate that this patient is covered by your plan.

26 = Your claim was for a prescription that was filled during a period when the patient was not covered by the plan. Your plan covered member only.

27 = Your claim was for a prescription that was filled during a period when the patient was not covered by the plan. Your plan covered member and spouse only.

28 = Your claim was for a prescription that was filled during a period when the patient was not covered by the plan. Your plan covered member and children only.

29 = Your claim was for a prescription that was filled during a period when the patient was not covered by the plan.

30 = Your claim does not provide a correct group number. Please obtain the correct group number from your plan sponsor.

31 = Your claim is for a prescription filled before your plan coverage thru paid prescriptions began. Please submit your claim to your previous carrier.

32 = No fee for group

33 = Your claim is for a prescription filled after the dependent became too old for coverage by the plan.

34 = Plan/group effective dates differ

35 = Invalid plan number

36 = Your claim is for a prescription filled after your plan coverage ended.

37 = Your claim was for a medication not covered by your plan.

38 = Your claim was for a medication which is not covered for a patient this age.

39 = Your claim is for an rx filled after your plan coverage ended.

3D = This claim is considered a duplicate because the same medication was purchased within three days of one another.

40 = Your claim did not provide a valid paid pharmacy number.

41 = Your claim indicated the prescription was not filled by a valid preferred provider organization (ppo) pharmacy as required by your plan.

42 = Specific pharmacy number required

44 = Direct reimbursement claims are not covered by your plan. These drugs may be payable through another carrier or claim processing agency.

45 = Your claim requires the client's signature. Please sign this form.

46 = Your claim requires the member's signature. Please sign this form.

47 = Your claim requires a pharmacy signature to verify the medicaton was dispensed. Please have the dispensing pharmacy sign this form.

48 = Your claim is not covered by the prescription drug plan; it may be covered by your mba. This claim has been forwarded toyour mba. Submit future claims of this type to your mba.

49 = No nabp number on file for this pharmacy

50 = Please indicate the 11 digit drug i.d. number (ndc#) for your prescription. If not available, the name and strength of the drug should be provided.

51 = Filled after coverage terminated

52 = Filled after coverage terminated

53 = Vitamins not covered under plan

54 = Fertility drugs not covered under plan

57 = Appliances not covered under plan

58 = Contraceptive drugs not covered under plan

59 = Injectable drugs not covered under plan

60 = Hemophiliac drugs not covered under plan

61 = Non-prescription drugs not covered under plan

62 = Syringes/needles not covered under plan

63 = The amount payable for this claim is less than your copayment.

64 = Payable amt greater than $210

65 = Compound limit $500

66 = Ingredient cost error (under billed by 50%)

67 = Your claim is for an amount greater than what we normally accept for this medication. You will need to provide a receipt to verify the amount paid.

68 = Ingredient cost variance (less than 50%)

69 = Your out of network claim is not eligible under this program. Please submit to your pos carrier for consideration

71 = This is a duplicate claim. We previously paid your pharmacy or applied the amount of your claim to your deductible.

72 = Duplicate pharmacy (current to current)

73 = This claim is considered a duplicate because the same or equivalent medication was purchased within three days of one another and therefore is not covered.

75 = Duplicate claim paid on current check

76 = Duplicate claim paid on current check

77 = This claim is a duplicate submission of a previously processed claim.

78 = Your claim requires the client's signature. Please sign this form.

7A = This is a duplicate claim. We previously paid your pharmacy for this claim.

7D = This claim is a duplicate submission of a previously processed claim.

7R = The rx# assigned to your prescription is the same as a previously paid claim. Please verify the correct rx# with your pharmacy and submit this form with this information.

7S = Duplicate claim paid on current check

7T = This claim is a duplicate of a previously rejected claim.

80 = Your claim is for an rx that was submitted after the allowable filing period.

85 = Unknown dupe check error

96 = Insured ineligible on prescription date

98 = Member eligible under two groups

99 = System error

AE = This claim requires an american equivalent (ae) drug number for processing. Your pharmacy may have this information. If there is no ae, your claim will not be reimbursed.

AO = Nplease provide nabp number for assignment of benefits.

AR = This claim requires an american equivalent (ae) drug number for processing. Your pharmacy may have this information. If there is no ae, your claim will not be reimbursed.

BA = This medication is not covered for a patient of the sex indicated on the claim form.

C1 = Patient is covered by another carrier for primary payment of this claim. After receipt of payment from primary carrier you may submit a cob form for any secondary coverage.

C2 = You did not submit the patient's primary insurance carrier explanation of benefits. Please resubmit this claim with the primary insurance carrier explanation of benefits.

C3 = The patient's primary carrier explanation of benefits does not contain sufficient information for processing.

C4 = Your group did not provide coordination of benefits on the date of service. Please contact your plan sponsor.

C5 = Our records indicate that the patient for whom the claim is submitted has medicare as a primary carrier. A cob claim may not be submitted for this patient.

C6 = The eob total prescription amount does not equal the total of the individual prescriptions on the cob claim form.

C7 = The eob reimbursed amount is greater than the eob total rx amount.

C8 = Every rx on this cob claim was rejected.

C9 = Your cob benefit does not reimburse for copayments on prescriptions.

CD = Your claim did not provide sufficient information for processing.

CG = Our records indicate another carrier is primary. Please submit to your primary carrier for processing. If this is a cob claim, submit directly to geha.

CM = This drug is not covered by your health plan. Please use your medicare benefit. If you have questions regarding the medicare coverage, please call 1-800-medare

CN = Our records indicate another carrier is primary. Please submit to your primary carrier for processing. Your coverage does not include cob.

CO = No copay option in effect on date filled.

CS = This claim is part of a cob claim containing one or more errors which must be corrected and resubmitted. Please make the necessary corrections and resubmit.

DL = Drug not covered/bc wa & al

DP = Filled before pharmacy start date or pharmacy class invalid

EC = This claim or a portion thereof has exceeded your plan limitations for this medication.

EG = To obtain prescriptions for your plan copayment, i.d. card must be presented to a participating pharmacy.

FC = Your prescription was written for a non-formulary medication which is not covered under your plan. Please consult your doctor to obtain a formulary alternative.

HH = Hh diff greater than 10% or $5 over calculated amount

KF = The presrription exceeds the monthly rx limitation.

LR = You have exceeded the lifetime maximum number of refills allowed for this drug under your plan.

LS = You have exceeded the lifetime maximum days' supply allowed for this drug under your plan.

M1 = Your prescription is not covered as the dispensing physician is not authorized to initiate therapy.

M2 = Drug not covered. Prior authorization required.

M3 = Your prescribing physician is not on the panel authorized toprescribe this drug.

MC = The receipt submitted is non conforming as it is missing the ndc number and quantity along with the information designated with an asterisk in the boxes below.

MD = Claim does not meet the minimum days supply of your plan.

MP = Your prescribing physician's id/dea # is required to process your claim. Please request that your pharmacist indicate this number on this form and return it as directed.

NA = Member address required, please enter addr1, city, zip

NM = The member number and last name you have provided does not match what we have on file for you. Please contact your customer service center/plan sponsor.

NP = Plan limits exceeded - non-maint pharmacy.

NR = Your claim was not dispensed at a retail pharmacy. The claim has been forwarded to your medical benefits administrator for further consideration.

NS = No subrogation allowed.

OD = Nthis brand name medication is not covered. Your plan only covers generic medications. Please call 1-800-234-1228.

PA = Drug not covered. Prior authorization required.

PC = Your presciption was written for a non-preferred medication which is not covered under your plan. Please consult your doctor to obtain a preferred drug.

PD = Claims are to be transmitted by participating pharmacies. Paper claims should not be submitted to paid prescriptions.

PE = Benefits are not payable, as you failed to use your prescription id card when filling this rx.

PO = No pricing option in effect on date filled.

PP = Patient ineligible for prescription drug program.

PQ = Please contact the medex service center to clarify your premium pay date information.

PR = Our records indicate your premium has not been paid.

PS = Paid to date suspension.

PT = Our records indicate your premium has not been paid.

QC = Claim held for quality review.

QP = Prior authorization required.

R1 = Your claim was not accompanied by the required pharmacy receipts. Please resubmit the claim with receipts attached.

R2 = Your plan requires either a receipt or a valid pharmacy number.

RA = Prior authorization required.

RD = Review for duplicate

RF = No refill allowed under plan.

RH = Dummy reject code for bcbsnj for one time shot purpose.

RT = Retro-term reprocessing.

RX = Your claim is for a refill that was dispensed sooner than your plan coverage allows.

SA = Your claim form did not indicate that the injectable was self administered. If self administered, please call member services at 1-800-770-2813 to initiate an appeal.

SH = Change member number to

SP = Claim is suspended

TV = Verify total charge and sales tax

VP = Invalid payee code for medicaid pharmacy

VQ = Quantity is <= 5, please verify

W1 = The worker's compensation case number/claim number reported on your claim form is not eligible for benefits. Please contact your employer for the correct case number/claim no.

W2 = Verify worker's compensation indicator (y/n)

WE = Drug not covered under workers comp claim

XA = Your claim did not provide the patient's correct date of birth.

XB = Your claim did not indicate the patient's sex.

XC = Your claim did not indicate whether the patient was the member, spouse, dependent, or other.

XD = Your claim did not provide the correct date that your rx was dispensed.

XE = Your claim did not provide the correct rx number. Please obtain the correct rx number from your pharmacy.

XF = Your claim did not provide the correct days supply. Please obtain the number of days worth of medication received from your pharmacy or receipt.

XG = Your claim did not provide your physician's full name or dea number.

XH = Your claim did not provide the quantity of medication you received.

XI = Invalid override code

XJ = Your claim form did not indicate the amount you paid for rx.

XK = Days supply exceeds this plan's retail limits.

XL = The group number provided on your claim form is invalid or missing. Please contact your customer service center/plan sponsor.

XM = Your claim did not provide a member number. Please contact your customer service center/plan sponsor.

XN = Invalid pharmacy code

XO = Invalid reject code

XP = Invalid claim number

XQ = Your claim did not indicate the patient's name.

XR = Your claim is for a refill. Your plan does not cover refills of your original rx.

XS = Your claim is for a second refill. Your plan only covers one refill of your original rx.

XT = Your claim is for a third refill. Your plan only covers two refills of your original rx.

XW = Cross foot error - notify i.s.

XX = Eligibility error - notify i.s.

YA = Invalid adjustment type

YB = Invalid adjustment date

YC = Invalid adjustment code

YD = Invalid adjustment group

YE = Invalid adjustment pair

YX = Negative adjustment pairs